



US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Concerns with Access to Care in the Outpatient Mental Health Clinic at the Charles George VA Medical Center in Asheville, North Carolina

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess concerns with access to care related to timely mental health assessment and treatment at the Charles George VA Medical Center's (facility) outpatient Mental Health clinic (clinic) in Asheville, North Carolina.

Complainants contacted the OIG in March and April 2022, alleging concerns regarding Behavioral Health Interdisciplinary Program (BHIP) assessment and psychotherapy consults; prescriber turnover in the clinic due to patient safety concerns, workload burden, and burnout; prescribers' scope of practice; community care consults; and the role of the suicide prevention team in the management of patients in crisis, including those with a high risk for suicide patient record flag (PRF).¹

On April 7, 2022, the OIG asked Veterans Integrated Service Network (VISN) 6 leaders to respond to allegations of insufficient staffing as well as poor quality and management of care in the clinic. The OIG found the May 6 response from the VISN deficient and on June 3, opened a hotline inspection to review the above allegations and facility leaders' response to concerns about access to mental health care.

Veterans Health Administration (VHA) outpatient mental health care includes general mental health services, evidence-based psychotherapy, and specialty mental health services, such as treatment for patients with posttraumatic stress disorder (PTSD) and military sexual trauma.² Patients must receive a diagnostic and treatment planning evaluation within 30 days of referral or request for mental health care.³

¹ Prescribing staff included psychiatrists, physician assistants, nurse practitioners, and clinical pharmacy specialists who provided medication management and other services to clinic patients. VHA Deputy Under Secretary for Health for Operations and Management, "General Mental Health Staffing Model Team Development: Behavioral Health Interdisciplinary Program (BHIP) Team-Based Care," memorandum to Network Directors, August 5, 2013; VHA Office of Mental Health Operations BHIP Implementation Team, "Behavioral Health Interdisciplinary Program (BHIP): Implementation Methodology," May 2019; VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021; VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. Facilities use a PRF in a patient's electronic health record to communicate to all VA staff that a patient is currently high risk for suicide.

² VHA Handbook 1160.01(1), *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. "Evidenced-Based Therapy," (webpage), VHA Mental Health, accessed October 20, 2022, <https://www.mentalhealth.va.gov/get-help/treatment/ebt.asp>. Evidence-based psychotherapies are mental health treatments that have shown improvement in a variety of mental health conditions. VHA MST Support Team, "Military Sexual Trauma," May 2021. Military sexual trauma is a term VHA uses to reference "sexual assault or sexual harassment experienced during military service." For this review, the OIG refers to psychotherapy as general psychotherapy, therapy for PTSD and military sexual trauma, as well as couples therapy.

³ VHA Handbook 1160.01(1).

VHA requires every facility have at least one BHIP team, composed of outpatient mental health providers and administrative support staff, who collaborate to offer patient services such as evaluation and treatment planning. BHIP teams ensure continuous access to mental health care.⁴

The OIG reviewed provider use of BHIP and psychotherapy consult processes, and reviewed relevant data and electronic health records (EHR) for patient safety concerns to determine if adverse clinical outcomes occurred due to consult delays.⁵ The OIG reviewed the EHRs of 11 patients whom clinic providers identified during interviews. The OIG learned

- two patients had delayed psychotherapy consults,
- two patients did not receive required suicide prevention care, and
- seven patients were alleged at risk for patient safety concerns due to provider workload burden; however, the OIG found no deficiencies in the care provided.

Delayed Access to Outpatient Mental Health Care

The OIG substantiated that access to mental health care was delayed related to BHIP and psychotherapy consult completion not meeting the VHA-required time frame. The OIG reviewed a sample of EHRs with consult delays and did not identify any adverse clinical outcomes. However, the OIG recognizes delays in care may increase the risk of adverse clinical outcomes and would expect facility leaders to proactively mitigate delays in consult completion.

Delays with BHIP Consults

The OIG analyzed completed BHIP consults, submitted from November 1, 2020, through June 30, 2022, and determined that 40.5 percent of BHIP consults did not meet the required completion time of 30 days from the patient indicated date (PID).⁶

Mental Health leaders told the OIG that BHIP consults are delayed due to multiple steps in the care process and that BHIP teams' meetings do not function efficiently. Further, the chief of

⁴ VHA Deputy Under Secretary for Health for Operations and Management, "General Mental Health Staffing Model Team Development: Behavioral Health Interdisciplinary Program (BHIP) Team-Based Care," memorandum; VHA Office of Mental Health Operations BHIP Implementation Team, "Behavioral Health Interdisciplinary Program (BHIP): Implementation Methodology."

⁵ For the purpose of this report, the OIG defines adverse clinical outcomes as a patient experiencing an inpatient hospitalization for psychiatric or substance use detoxification needs, an overdose or a suicide behavior reported through a Suicide Behavior and Overdose Report, or death, between submission and completion of consults for mental health services or, for incomplete consults, to the date of OIG review.

⁶ VHA Directive 1230(5), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended September 24, 2021. This directive was in place during the time of events discussed in this report and rescinded and replaced by VHA Directive 1230, *Outpatient Scheduling Management*, June 1, 2022. The new directive replaced the "Clinically Indicated Date" with "Patient Indicated Date." The PID "is the date the health care provider and Veteran agree is clinically indicated for care. In the absence of health care provider input, the PID is the Veteran's preferred date."

Mental Health told the OIG that one of the four positions for licensed professional counselors, who complete the BHIP consults, was vacant; however, wait times were expected to decrease upon filling the vacancy.⁷

Delays with Psychotherapy Consults

The OIG analyzed all completed consults related to psychotherapy, PTSD, military sexual trauma, and couples therapy, submitted from November 1, 2020, through June 30, 2022, and found that 39.3 percent of psychotherapy, 39.5 percent of PTSD, 27 percent of military sexual trauma, and 67.8 percent of couple's therapy consults did not meet the required completion time of 30 days from the PID.

Mental Health leaders told the OIG that psychotherapy consult delays occurred because

- staffing issues limit the number of therapy providers to complete the consults,
- therapists are backlogged and patients must wait to start psychotherapy, and
- the Clinical Resource Hub is no longer available due to Hub staffing concerns.⁸

VHA encourages streamlined processes for patients to ensure open access to care. When a patient's needs can be addressed by a specialty Mental Health program, an assignment to a BHIP team is not necessary.⁹ The OIG found clinic providers did not fully understand the psychotherapy consult process; the majority of prescribers incorrectly believed that "permission" from the BHIP team was required before placing a psychotherapy consult. Additionally, the OIG found Mental Health leaders responded to delays in BHIP consults through ongoing process improvement but did not clearly communicate with each other or fully address misperceptions about the psychotherapy consult process.

Prescriber Turnover in the Outpatient Mental Health Clinic

The OIG determined the facility did not have processes to ascertain why staff leave so as to inform retention strategies that are necessary to maintain staffing levels for accessible patient care. The Facility Director reported the intention to conduct exit interviews in the future.

⁷ On November 14, 2022, the chief of Mental Health informed the OIG that the licensed professional counselor vacancy was filled on October 23, 2022.

⁸ "Clinical Resource Hubs (CRH)" (webpage), VHA Patient Care Services, accessed December 12, 2022, <https://www.patientcare.va.gov/primarycare/CRH.asp>. VISNs operate Clinical Resource Hubs and provide direct care (primarily through telehealth) to patients when local facilities have gaps in service capabilities. On August 8, 2022, the chief of Mental Health reported Mental Health has reapplied for assistance through the Clinical Resource Hub.

⁹ VHA Office of Mental Health Operations BHIP Implementation Team, "Behavioral Health Interdisciplinary Program (BHIP): Implementation Methodology."

The OIG reviewed prescriber staffing at the clinic from November 2020 through June 2022, and found four prescribers had left the clinic.¹⁰ Three former prescribers told the OIG of leaving the clinic due to their concerns regarding patient safety issues, workload burden, and burnout. When asked by the OIG, the former section chief of the clinic denied there were patient safety issues related to the concerns expressed by prescribers.¹¹

The OIG could not determine if prescribers left the clinic at a higher or lower rate compared to mental health staff at other facilities, as VHA does not track Mental Health staff at a specific clinic or staff position levels in a uniform way.

OIG Review of Mental Health Staffing

The OIG reviewed clinic staffing levels, which is a component of accessible care, to determine compliance with VHA requirements. The OIG found that although the minimum required full-time equivalent (FTE) employee staff was met, the Facility Director reported critical clinical staffing shortages in Mental Health Service; specifically, psychology and substance use disorder nurse practitioners for fiscal year 2022, and Mental Health Service faced challenges in recruiting providers.¹² The OIG reviewed clinic staffing data from November 2020 through June 2022, and found the facility met the required staffing ratio.¹³

The chief of Mental Health told the OIG that upon becoming the chief on January 31, 2021, “my first order of business was to fill vacancies.”¹⁴ Additionally, the Facility Director told the OIG of ongoing efforts to navigate these barriers, such as scarcity of providers in Western North Carolina and high cost of living in Asheville, by requesting a locality pay adjustment and

¹⁰ One psychiatrist and one physician assistant transferred within the facility, one psychiatrist resigned from the VA, and one physician assistant transferred to another VA facility.

¹¹ The OIG also reviewed the Mental Health service’s Joint Patient Safety Reports from November 1, 2020, through June 30, 2022, and did not find reports related to provision of care in Mental Health. “Frequently Asked Questions” (webpage), VHA National Center for Patient Safety, accessed September 30, 2022, <https://www.patientsafety.va.gov/about/faqs.asp>. The Joint Patient Safety Reporting System is the VHA’s patient safety event reporting system and database.

¹² VA OIG, *OIG Determination of Veterans Health Administration’s Occupational Staffing Shortages Fiscal Year 2022*, Report No. 22-00722-187, July 7, 2022; VHA Directive 1161, *Productivity and Staffing in Clinical Encounters for Mental Health Providers*, April 28, 2020. “Full Time Equivalent Clinical (FTE(c)) is the portion of a full-time equivalent employee (removing leave) which is devoted to clinical, direct patient care.” VHA recommends a minimum of 7.72 outpatient clinical FTE for every 1,000 patients receiving mental health care.

¹³ The OIG noted the clinical FTE in the clinic, while above required levels, had declined from 9.73 FTE in quarter three of fiscal year 2021 to 8.3 FTE in quarter three of fiscal year 2022.

¹⁴ Prior to January 31, 2021, the chief of Mental Health was the assistant chief of Mental Health. Additionally, facility leaders told the OIG that all Mental Health staff vacancies are expedited.

implementing hiring incentives when applicable, such as recruitment and retention pay and telework.¹⁵

The OIG determined that although the Mental Health Service has addressed prescribers' perceived workload burden by backfilling clinic position vacancies, the Service lacks an organized process to evaluate why prescribers leave, which would likely be informative for staff retention strategies.

Prescribers' Scope of Practice

The OIG did not substantiate prescribers were providing care outside of their scope of practice. The OIG reviewed requirements for prescribers with varying credentials, and found they practiced within their privileges or scopes of practice, as applicable.

While prescribers reported not practicing outside of privileges, during OIG interviews, clinical pharmacy specialists stated it was hard to find assistance for patients presenting with needs outside their scope of practice.¹⁶ The OIG found facility leaders clarified the role of clinical pharmacy specialists; however, the OIG learned from the chief of Mental Health there were delays with addressing the matter after leaders' awareness that clarification was needed.

The OIG asked the associate chief of Pharmacy about clinical pharmacy specialists continued concerns about practicing outside of their scope. The associate chief of Pharmacy reported the chief of Pharmacy had a "cursory, high-level awareness" of the prescriber's concerns, but deferred to Mental Health Service as to procedures and questions of care coordination.

The OIG concluded that Mental Health leaders failed to promptly clarify the role of clinical pharmacy specialists and the associate chief of Pharmacy did not directly communicate concerns regarding scope of practice with the chief of Pharmacy.

Mental Health Leaders' Unclear Communication Regarding Use of Community Care Consults

The OIG substantiated facility Mental Health leaders discouraged clinic providers from entering community care consults by expressing the need to minimize expenses and maintain patient care at the facility. However, the OIG found providers did refer patients to community care.

¹⁵ Following the OIG's interview with the Facility Director, the facility received a denial for the requested locality pay in August 2022. Federal Salary Council, *Report of the Federal Salary Council Working Group*, August 5, 2022.

¹⁶ In mid-March 2022, prescribers filed a union complaint, which outlined concerns about the potential risk of clinical pharmacy specialists practicing outside of their scope due to increased patient care needs.

When mental health care cannot be provided directly through the VA, a patient may receive care in the community based on specific eligibility requirements.¹⁷ During interviews

- prescribers told the OIG that the chief of Mental Health told them it was important to keep patient care at the facility due to the expense of community care;
- the chief of Mental Health shared the goal to “recapture veteran care” and Mental Health staff may have misunderstood the message; and
- the Chief of Staff said the message of using community care “could easily be misconstrued” and believed prescribers did not understand the consult process.¹⁸

The OIG reviewed all mental health community care consults submitted between November 1, 2020, and June 30, 2022, and found nearly all the prescribers, as well as additional non-prescribing clinic providers, submitted consults for community care.

The OIG did not find Mental Health leaders prohibited the use of community care as clinic providers placed community care consults during the period of review. However, providers may benefit from additional guidance on the use of community care consults.

Alleged Lack of Assistance from the Suicide Prevention Team

The OIG did not substantiate that the suicide prevention team failed to support prescribers with clinical duties, including patients with a PRF. However, the OIG identified a general misunderstanding by some prescribers about the role of the suicide prevention team.

A suicide prevention team “generally focus[es] on oversight and monitoring, rather than providing direct patient care,” and provides “supplemental” care to patients with a PRF, such as telephone contacts if the patient is not keeping scheduled appointments.¹⁹

Prescribers interviewed were unaware that the suicide prevention team’s duties are primarily administrative and reported the belief that the suicide prevention team is primarily responsible for the outreach and management of suicidal patients or patients with a PRF. Mental Health

¹⁷ VHA Handbook 1160.01(1); VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393, § 101 (2018); VHA Office of Community Care, “Veteran Community Care: General Information,”(fact sheet) September 9, 2019. Eligibility criteria for care in the community includes available options at VA; facility and community wait times; and average patient travel time of 30 minutes.

¹⁸ After the OIG’s onsite inspection, the chief of Mental Health provided clarification to all Mental Health staff that providers should submit community care consults as needed for patient care.

¹⁹ VHA Office of Mental Health and Suicide Prevention, “Suicide Prevention Program Guide,” updated November 1, 2020, p. 48; Charles George VA Medical Center Memorandum 637-116-11, *Suicide Assessment, Intervention, and Documentation*, August 2019, amended August 2020, p. 6.

leaders reported awareness of these concerns but failed to reeducate the staff on the role of the suicide prevention team.

The OIG concluded that the failure of Mental Health leaders to communicate the role of the suicide prevention team in the management of suicidal or at risk of suicide patients could result in missed interventions.

Clinic providers alleged the care provided to two patients did not meet VHA suicide prevention requirements. The OIG determined the suicide prevention team failed to monitor and manage VHA-required follow-up care for two patients with PRFs; however, neither experienced an adverse clinical outcome.

VHA requires clinical staff to screen patients for suicidal risk and providers to complete safety plans using a required EHR template and collaborate with the suicide prevention team when a patient requires the placement of a PRF.²⁰ The suicide prevention team must ensure documentation of a safety plan on the required template and that the patient completes four mental health follow-up appointments within 30 days of a PRF placement.²¹

The OIG reviewed the patients' episodes of care in the EHR, as defined by the clinic provider, and found that for the two patients

- neither completed four appointments within 30 days of the PRF placement, and
- one patient did not receive a completed safety plan using the required EHR template within 7 days of the PRF placement.

The suicide prevention coordinator explained to the OIG that for one patient, the suicide prevention team failed to identify a scheduling discrepancy. For a second patient, the suicide prevention team was unable to contact the patient and the OIG did not identify documentation of further attempts by suicide prevention staff to contact the patient.

The OIG made seven recommendations to the Facility Director related to mental health consult scheduling, community care referrals, BHIP implementation, staff retention, leaders'

²⁰ VHA Deputy Under Secretary for Health for Operations and Management (DUSHOM), "Eliminating Veteran Suicide: Implementation of Suicide Risk Screening and Evaluation," memorandum to Veterans Integrated Service Network (VISN) Directors, VISN Mental Health Leads, and Medical Center Directors, November 2, 2018; VHA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide." Safety plans are required for patients with a PRF, a recent suicide attempt, or admission to psychiatric or residential treatment. Facility care coordination agreements, 2019 and 2022.

²¹ VHA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide;" VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO), "Update to High Risk for Suicide Patient Record Flag (HRS-PRF) Changes," memorandum to Veterans Integrated Service Network (VISN) Directors, VISN CMOs, and VISN Chief Mental Health Officers, October 5, 2021. This memorandum clarified that a safety plan must be completed within seven days of a PRF.

communication, the role of the suicide prevention team, and follow-up care for patients with high risk for suicide patient record flags.

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

A handwritten signature in black ink that reads "John D. Daigh, Jr., M.D." The signature is written in a cursive style.

JOHN D. DAIGH, JR., M.D.
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Abbreviations

| | |
|-------|---|
| BHIP | Behavioral Health Interdisciplinary Program |
| EHR | electronic health record |
| HRO | high reliability organization |
| OIG | Office of Inspector General |
| PCMHI | Primary Care Mental Health Integration |
| PID | patient indicated date |
| PRF | patient record flag |
| PTSD | posttraumatic stress disorder |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess concerns with access to care related to timely mental health assessment and treatment at the Charles George VA Medical Center's (facility) outpatient Mental Health clinic (clinic) in Asheville, North Carolina.

Background

The facility is part of Veterans Integrated Service Network (VISN) 6 and includes three community-based outpatient clinics. The Veterans Health Administration (VHA) classifies the facility as a level 1c, mid-high complexity.¹ From October 1, 2020, through September 30, 2021, the facility had 103 hospital, 73 community living center, and 14 domiciliary operating beds, and served 47,295 patients. Additionally, there are three local Vet Centers near Asheville where patients may access mental health care: one 40 miles away in Spindale, North Carolina; the second 52 miles away in Greenville, South Carolina; and the third 53 miles away in Johnson City, Tennessee.²

Patient Safety and High Reliability Organizations

The National Center for Patient Safety started VHA's "Journey to High Reliability," which provides a framework for effective leadership, prevention of harm, and continuous process improvement. The goal is to transform workplace culture and empower "dedicated, compassionate VHA employees" to provide high quality and safe patient care.³

In 2018, VHA established the High Reliability Organization (HRO) Steering Committee to "define the vision, Principles and Values of VHA's Journey to High Reliability."⁴ HROs begin with leaders who engage staff at all levels of the organization. VHA's National Center for Patient Safety recognizes leaders' communication and actions as vital in creating a culture of patient

¹ VHA Office of Productivity, Efficiency and Staffing, "Facility Complexity Model Fact Sheet," January 28, 2021. The VHA Facility Complexity Model categorizes medical facilities by complexity-based level on patient population, clinical services offered, and educational and research missions. Complexity levels include 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex.

² VHA Directive 1500(2), *Readjustment Counseling Service*, January 26, 2021, amended December 30, 2021. Vet Centers offer counseling for psychological and psychosocial readjustment problems.

³ "VHA High Reliability Organization (HRO) Reference Guide," (web page), <https://dvagov.sharepoint.com/sites/OHT-PMO/high-reliability/Documents/VHA%20HRO%20Reference%20Guide.pdf>, p. 3, 5. (This web page is not publicly accessible.)

⁴ "VHA High Reliability Organization (HRO) Reference Guide," p. 7 (web page).

safety as “poor communication has been proven to put patients in jeopardy.”⁵ The commitment of leaders is considered the most critical element to change and requires “participation of highly visible and vocal leaders to promote and demonstrate their sustained commitment to HRO transformation through their actions.”⁶ VHA’s established HRO principles, which are the foundation of the “Journey to High Reliability,” help guide a facility’s performance improvement. VHA expects facility leaders to model the HRO principles, which include processes that affect patient care, as well as anticipate and eliminate risks, including

- “Preoccupation with Failure,” in which risks to patient care are anticipated and eliminated before they happen, and
- “Sensitivity to Operations,” in which leaders should consider the processes that affect patient care.⁷

The OIG reviewed the facility leaders’ response to the concerns in the context of HRO principles related to process improvement, communication, and patient safety.

Prior Reports

In May 2022, the OIG published a review of VHA efforts to address employee’s emotional well-being during the COVID-19 pandemic.⁸ The OIG found “a generally diminishing awareness of supports in relation to organizational hierarchy, low utilization of support resources by both leadership and frontline employees, as well as employee perception of inadequate support and responsiveness from leadership.”⁹ The OIG made one recommendation related to increasing

⁵ “VHA High Reliability Organization (HRO) Reference Guide,” (web page), Joe Murphy, “Center of Excellence, Developing a Culture of Safety,” *Federal Practitioner* E3, (January 2013), p.1; Gary Sculli and Robin Hemphill, “Culture of Safety and Just Culture,” *VHA National Center for Patient Safety*, accessed October 20, 2022, https://www.patientsafety.va.gov/docs/joe/just_culture_2013_tagged.pdf (site discontinued).

⁶ “VHA High Reliability Organization (HRO) Reference Guide,” p. 6 (web page).

⁷ “VHA High Reliability Organization (HRO) Reference Guide” (web page).

⁸ VA OIG, *The Veterans Health Administration Needs to Do More to Promote Emotional Well-Being Supports Amid the COVID-19 Pandemic*, Report No. 21-00533-157, May 10, 2022; Mayo Clinic, “coronavirus disease 2019 (COVID-19),” accessed October 18, 2022, <https://www.mayoclinic.org/diseases-conditions/coronavirus/symptoms-causes/syc-20479963>. COVID-19 is from a family of viruses that can cause illnesses and known as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2); *Merriam-Webster.com Dictionary*, “pandemic,” accessed October 18, 2022, <https://www.merriam-webster.com/dictionary/pandemic>. “[A]n outbreak of a disease that occurs over a wide geographic area (such as multiple countries or continents) and typically affects a significant proportion of the population.”

⁹ VA OIG, *The Veterans Health Administration Needs to Do More to Promote Emotional Well-Being Supports Amid the COVID-19 Pandemic*, p. 11.

awareness of available resources on the potential risks and signs of burnout.¹⁰ The recommendation remains open as of May 1, 2023.

In a July 2022 report, the OIG surveyed VHA facilities on self-reported occupational staffing shortages for fiscal year 2022.¹¹ The OIG found a 22 percent increase in self-reported severe occupational staffing shortages as compared to the previous year. The Facility Director reported severe occupational staffing shortages in 13 clinical positions, including Mental Health Service positions of psychology and substance use disorder nurse practitioners. Severe shortages in psychology were not unique to the facility as 73 of the 139 facilities surveyed for fiscal year 2022 reported shortages, making psychology the fourth most reported occupational shortage. No recommendations were made.¹²

Allegations

Several complainants contacted the OIG from March 15 through April 18, 2022, alleging

- delayed access to outpatient mental health care related to
 - timely completion of Behavioral Health Interdisciplinary Program (BHIP) assessment consults and psychotherapy consults, and
 - a prohibition against entering psychotherapy consults prior to BHIP team completing consultation;
- prescribing staff (prescribers) turnover in the clinic was due to concerns with patient safety, workload burden, and burnout;
- prescribers provided care outside of their scope of practice;
- Mental Health leaders discouraged the use of community care consults, and

¹⁰ VA OIG, *The Veterans Health Administration Needs to Do More to Promote Emotional Well-Being Supports Amid the COVID-19 Pandemic*; Merriam-Webster.com Dictionary, “burnout,” accessed October 18, 2022, <https://www.merriam-webster.com/dictionary/burnout>. “[E]xhaustion of physical or emotional strength or motivation usually as a result of prolonged stress or frustration.”

¹¹ VA OIG, *OIG Determination of Veterans Health Administration’s Occupational Staffing Shortages Fiscal Year 2022*, Report No. 22-00722-187, July 7, 2022; “Budget of the US Government,” (web page) USA.gov, accessed November 30, 2022, <https://www.usa.gov/budget#:~:text=The%20federal%20government%27s%20fiscal%20year,September%2030%20of%20the%20next>. The federal government defines a fiscal year as October 1 of a calendar year through September 30 of the next year. Fiscal year 2022 started on October 1, 2021, and ended September 30, 2022.

¹² VA OIG, *OIG Determination of Veterans Health Administration’s Occupational Staffing Shortages Fiscal Year 2022*; Direct-Hire Authority, 5 C.F.R. § 337.204 (2004). A severe shortage refers to particular occupations that are difficult to fill and a shortage exists.

- the suicide prevention team was not available to support clinic prescribers with patients in crisis, including those with a high risk for suicide patient record flag (PRF).¹³

On April 7, 2022, the OIG asked VISN 6 leaders to respond to allegations of insufficient staffing as well as poor quality and management of care in the clinic; denial of individual therapy and community care consults; and concerns about the culture within the clinic. On May 6, the OIG received the VISN response, which was signed by the Facility Director, and noted all allegations as unsubstantiated.

The OIG found the VISN response did not fully address management of care in the clinic, such as the availability for mental health care through same-day access and community care consults or the alleged burden of care on prescribers, and action taken by facility leaders to address the concerns regarding the culture in the Mental Health Service. On June 3, the OIG opened a hotline inspection to review the above allegations and to further review the outpatient Mental Health staffing levels to determine whether the clinic was operating at required levels. The OIG also evaluated facility leaders' response to concerns about the access to care in the clinic.

Scope and Methodology

The OIG initiated the inspection on June 8, 2022, and conducted a hybrid of virtual and on-site interviews from July 13 through August 30, 2022. The OIG interviewed facility leaders; Mental Health staff including Mental Health supervisory staff, the Mental Health administrative officer, the Mental Health data manager, a Mental Health program support assistant, a suicide prevention coordinator; and the prescribers, which included psychiatrists, physician assistants, and clinical

¹³ Prescribing staff include psychiatrists, physician assistants, nurse practitioners, and clinical pharmacy specialists who provide medication management and other services to clinic patients. VHA Deputy Under Secretary for Health for Operations and Management, "General Mental Health Staffing Model Team Development: Behavioral Health Interdisciplinary Program (BHIP) Team-Based Care," memorandum to Network Directors, August 5, 2013; VHA Office of Mental Health Operations BHIP Implementation Team. "Behavioral Health Interdisciplinary Program (BHIP): Implementation Methodology." May 2019. BHIP teams ensure interdisciplinary continuous access to ongoing mental health care for patients established in Mental Health and for patients new to the VHA system whose care is provided by specialty mental health or within primary care; VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021. A suicide prevention team can consist of various facility designated staff, who are dedicated to implementing the suicide prevention program at the facility; VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. VA medical centers use a PRF in a patient's EHR to communicate to all VA staff that a patient is currently high risk for suicide.

pharmacy specialists.¹⁴ Additionally, the OIG interviewed a medical support assistant supervisor in Care in the Community.¹⁵

The OIG reviewed relevant VHA directives and handbooks, as well as facility policies, standard operating procedures, and care coordination and service agreements related to the clinic, consults, clinical pharmacy, community care, and suicide prevention. Documents reviewed were relevant to the period from November 2020 through June 2022, including electronic health records (EHRs) for 11 patients whom clinic providers identified as having access to care issues; patient safety reports; Mental Health consult data; clinic providers' scope of practice, privileging, and functional statements; facility Mental Health vacancy and recruitment data; VHA Office of Mental Health and Suicide Prevention Mental Health Staffing and Productivity Dashboard data; and other documents relevant to the inspection.

The OIG retrieved and reviewed patient data from VA's Corporate Data Warehouse, including consult titles, to determine patient wait times for mental health care.¹⁶ The OIG reviewed BHIP consults for a sample of patients' who experienced delayed consults of greater than 45 days to determine trends such as scheduling, ordering provider, and services provided. The OIG conducted EHR reviews for adverse clinical outcomes for the patients who experienced unexplained delays, as determined by the OIG, and patients who experienced delayed BHIP consults of 90 days or greater.¹⁷ Additionally, the OIG issued a subpoena for one patient's death certificate, which was received and reviewed.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

¹⁴ Facility leaders included the Facility Director, Chief of Staff, the chief of Mental Health, and the associate chief of Pharmacy. Per facility functional statements, clinical pharmacy specialists provide "highly innovative and progressive clinical pharmacy services through direct patient care."

¹⁵ The Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 132 Stat. 1427 (2018). A patient may be eligible for care in the community when a service is not available or not available within a specific time frame at VA, or it is in the patient's best medical interest to be referred to a community provider.

¹⁶ "Corporate Data Warehouse (CDW)," (web page), VA Health Services Research and Development, accessed on October 18, 2022, https://www.hsrd.research.va.gov/for_researchers/vinci/cdw.cfm. The Corporate Data Warehouse is made up of four regional data warehouses to standardize, consolidate, and streamline clinical data systems to provide a high-performance business intelligence infrastructure.

¹⁷ For the purpose of this report, the OIG defines adverse clinical outcomes in this context as a patient experiencing an inpatient hospitalization for psychiatric or substance use detoxification needs, an overdose or a suicide behavior reported through a Suicide Behavior and Overdose Report, or death, between submission and completion of consults for mental health services or, for incomplete consults, to the date of OIG review. VHA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide," updated November 1, 2020. The Suicide Behavior and Overdose Report is a standardized EHR note to document patient's suicidal behavior and non-suicidal overdose events within the last 12 months.

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Patient Case Summaries

Patient 1

Patient 1 was in their 20s when VA care was initiated with a primary care provider at the North Charlotte VA Clinic in early spring 2014.¹⁸ The patient reported a past medical history of depression, four previous hospitalizations, and two suicide attempts. The primary care provider entered a consult for ongoing medical management with Psychiatry Service. Approximately one month later, Patient 1 met with a psychiatrist for an initial mental health evaluation. The psychiatrist diagnosed the patient with recurrent major depressive disorder, polysubstance abuse, and generalized anxiety disorder, and noted the patient was at moderate risk for suicide with three past suicide attempts.¹⁹ Four months later, the patient contacted the Veterans Crisis Line

¹⁸ The OIG uses the singular form of they, “their” in this instance, for privacy purposes. The patient visited the North Charlotte VA Clinic, part of VA Salisbury Healthcare System. “Locations,” (web page), VA Salisbury Health Care, accessed December 12, 2022, <https://www.va.gov/salisbury-health-care/locations/>.

¹⁹ Mayo Clinic, “Depression (major depressive disorder),” accessed April 18, 2023, <https://www.mayoclinic.org/diseases-conditions/depression/symptoms-causes/syc-20356007>. “Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest;” “Substance Abuse/Chemical Dependency,” (web page) Johns Hopkins Medicine, accessed October 25, 2022, https://www.hopkinsmedicine.org/healthlibrary/conditions/adult/mental_health_disorders/substance_abuse_chemical_dependency_85.p00761. “Substance dependence is the medical term used to describe abuse of drugs or alcohol that continues even when significant problems related to . . . use have developed;” “Polysubstance Use Facts,” (web page) Centers for Disease Control and Prevention, accessed on October 27, 2022, <https://www.cdc.gov/stopoverdose/polysubstance-use/index.html>. Polysubstance use is “[t]he use of more than one drug;” “Generalized Anxiety Disorder (GAD),” (web page) Johns Hopkins Medicine, accessed October 27, 2022, <https://www.hopkinsmedicine.org/health/conditions-and-diseases/generalized-anxiety-disorder>. Generalized anxiety is when a person has difficulty controlling constant worry and a diagnosis of generalized anxiety disorder may result if worry occurs most days for at least six months.

and reported feeling overwhelmed and decided to access local emergency care.²⁰ From late summer 2014 through early fall 2018, the patient received medication management intermittently from six psychiatrists across two VA facilities.²¹

In mid-summer 2021 (Day 1), the patient contacted the facility to request mental health treatment for symptoms including suicidal ideation, and spoke to a mental health nurse who documented suicidal ideation with “no current plan or intent” and notified a facility clinic physician assistant. That same day, the physician assistant contacted the patient by phone, obtained the patient’s history, diagnosed the patient with posttraumatic stress disorder (PTSD) and bipolar II disorder, and noted the patient to be “at moderate acute and low chronic risk for suicide,” but had “no intention or plan to kill [themselves].”²² The physician assistant submitted a consult for a BHIP assessment that was scheduled for approximately two weeks later.

Day 2, the physician assistant again met with the patient to conduct a comprehensive suicide risk evaluation and to prepare a Suicide Prevention Safety Plan.²³ Day 3, the physician assistant contacted the suicide prevention team and requested a PRF. A suicide prevention team member placed the PRF in the patient’s EHR the same day.

Day 4, a social worker spoke with the patient and documented that although the patient had suicidal ideation, the patient “met with [Mental Health],” and case management needs were resolved. Day 8, the physician assistant documented providing the patient medication management and supportive psychotherapy. Day 10, the patient called the Veterans Crisis Line. The Veterans Crisis Line responder had concerns about the patient’s safety and contacted the local police who reported going to the patient’s home and “assessed [the patient] as safe and that

²⁰ “About Us,” (web page), Veterans Crisis Line, accessed October 6, 2022, <https://www.veteranscrisisline.net/about/about-us/>. “[T]he Veterans Crisis Line is a free, confidential resource that connects [a caller] to a real person specially trained to support Veterans.”

²¹ The patient visited the North Charlotte VA Clinic, and the W. G. (Bill) Hefner Salisbury VA Medical Center, both locations are part of the Salisbury VA Health Care System.

²² American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5-TR)*, “Trauma and Stressor-Related Disorders,” accessed October 25, 2022,

[Libhttps://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425787.x07_Trauma_and_Stressor_Related_Disorders#BABJAEHerry](https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425787.x07_Trauma_and_Stressor_Related_Disorders#BABJAEHerry). PTSD is a trauma-related disorder that evolves after a person is exposed to serious injury, potential death, or sexual violence through direct experience, as a witness, hearing of a close family or friend’s experience, or repeated exposure to details of experiences (such as a first responder); *DSM-5 TR*, “Bipolar and Related Disorders,” accessed October 25, 2022,

https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425787.x03_Bipolar_and_Related_Disorders. Bipolar II, a type of bipolar disorder, is characterized by recurring mood episodes of at least one major depressive episode and one hypomanic episode. A hypomanic episode is a period of at least four days in a row when a person has “abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy.”

²³ VHA Office of Mental Health and Suicide Prevention, “Suicide Prevention Program Guide.” A safety plan includes a prioritized list of coping strategies and resources patients develop in collaboration with their provider to maintain safety and navigate crises.

a friend will be staying with [the patient].” On Day 11 and Day 14, the physician assistant followed-up with the patient and provided medication management and supportive psychotherapy.

Day 15, the patient did not show for the previously scheduled BHIP assessment and did not answer a provider’s call about the missed appointment. Two days later when an appointment scheduler attempted to call the patient, there was no answer and the voicemail box was full. On Day 19, the appointment scheduler noted in the EHR that the patient was in the custody of the local county sheriff and was being monitored for suicidal risk. On Day 22, the physician assistant spoke with the patient, who expressed interest in voluntary inpatient admission for mental health treatment. The same day, the patient presented to the facility’s Emergency Department, tested positive for COVID-19, and was admitted to the COVID-19 medical unit instead of inpatient mental health. The patient was placed on one-to-one observation for suicide risk. The next day, an inpatient mental health psychiatrist evaluated the patient and discontinued the one-to-one observation. The following day, the patient became agitated and requested to leave the facility, stating not wanting to be on a COVID-19 unit, and left against medical advice.

On Day 24, the patient met with the physician assistant, who documented the patient denied having suicidal thoughts, the plan to continue medications and return for a visit in one week, as well as two additional therapy appointments scheduled for three weeks later. During the visit with the physician assistant, the patient’s previously missed BHIP consult was rescheduled for seven weeks later. Four days after the Day 24 appointment with the physician assistant, the patient died from injuries caused by a motorcycle accident.

Patient 2

Patient 2, who was in their 40s, had a past medical history significant for PTSD, insomnia, suicide attempts, and inpatient psychiatric hospitalizations.²⁴ Late winter 2022, the patient was admitted to another VA medical center after reporting suicidal plans and intent.

Eight days following the admission, a facility clinic physician assistant met with the patient and completed a post-discharge evaluation and documented that the patient was hospitalized the week prior for suicidal ideation. The physician assistant reviewed the patient’s medications for PTSD, insomnia, depression, and anxiety, and documented the patient wanted psychotherapy. Six days after the appointment with the physician assistant, during a BHIP team meeting, the physician assistant requested therapy for the patient and documented the team’s recommendations to consider the patient for group therapy and submit a general psychotherapy consult. The physician assistant called the patient to offer group therapy, the patient accepted,

²⁴ Mayo Clinic, “Insomnia,” accessed April 18, 2023, <https://www.mayoclinic.org/diseases-conditions/insomnia/symptoms-causes/syc-20355167>. “Insomnia is a common sleep disorder that can make it hard to fall asleep, hard to stay asleep, or cause you to wake up too early and not be able to get back to sleep.”

and subsequently the physician assistant submitted a psychotherapy consult in the EHR. Approximately two months later, a psychologist completed the general psychotherapy consult.

Patient 3

Patient 3, who was in their 30s with a history of adjustment disorder with depression and insomnia, attended a new patient appointment at a facility community-based outpatient clinic in early fall 2019.²⁵ The primary care provider submitted a consult for mental health services following the patient's positive screening results for PTSD. Two weeks later, a psychologist completed the consult, diagnosed the patient with "Other Specified Trauma- & Stressor-Related Disorder w/PTSD features," and referred the patient to a facility clinical pharmacy specialist for medication management. Between fall of 2019 and fall of 2021, the patient had one in-person visit, two telehealth visits, three telephone appointments, and seven secure message contacts with the clinical pharmacy specialist for medication management.²⁶

Early 2022, the patient met with the clinical pharmacy specialist and denied current suicidal thoughts but reported thinking of suicide five days prior. The clinical pharmacy specialist documented completion of "informal although thorough safety planning" with the patient, a comprehensive suicide risk evaluation, and a Suicide Behavior and Overdose Report for review by the suicide prevention team.²⁷ Additionally, the clinical pharmacy specialist documented a plan to present and discuss the patient's request for psychotherapy at the next BHIP team meeting.²⁸ On the same day, a suicide prevention team staff member placed a PRF in the patient's EHR and alerted the clinical pharmacy specialist about the flag through the EHR.

Three days after meeting with the clinical pharmacy specialist, the patient sent a secure message to the clinical pharmacy specialist, reporting increased rage that was becoming difficult to control. The next morning, the clinical pharmacy specialist replied, "I have you on the schedule tomorrow morning to present to the team and will let you know what we decide on where to start

²⁵ Mayo Clinic, "Adjustment disorders," accessed April 18, 2023, <https://www.mayoclinic.org/diseases-conditions/adjustment-disorders/symptoms-causes/syc-20355224>. A stress-related condition that occurs when individuals experience "more stress than would normally be expected in response to a stressful or unexpected event" such as work problems, illness, or death of a close family member.

²⁶ "VA secure messaging" (web page), VA, accessed October 5, 2022, <https://www.va.gov/health-care/secure-messaging/>. Secure messages allow patients to communicate privately online with their healthcare teams.

²⁷ VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO), "Update to High Risk for Suicide Patient Record Flag (HRS-PRF) Changes," memorandum to Veterans Integrated Service Network (VISN) Directors, VISN CMOs, and VISN Chief Mental Health Officers, October 5, 2021. Should a patient choose not to complete a safety plan, then "providers must document the patient's decision to decline a safety plan in the EHR." The clinical pharmacy specialist's EHR documentation noted not completing the safety plan as the patient "refused" giving the reason of time constraints.

²⁸ BHIP team meetings occurred every Wednesday.

with therapy.” Two days later, the clinical pharmacy specialist submitted a psychotherapy consult for PTSD, which was scheduled for approximately two months later.

While waiting for completion of the consult, the patient communicated with the clinical pharmacy specialist through a secure message and reported, despite having “good and bad days,” overall was feeling better. Early spring 2022, the patient saw the clinical pharmacy specialist in-person and the clinical pharmacy specialist documented that the patient had 50 percent improvement in mood and “fleeting passive suicidal ideation” without any suicidal intent or plan.

Later the same month, the PTSD provider completed the patient’s consult and ongoing psychotherapy was scheduled. Two weeks later, the patient met with the clinical pharmacy specialist and reported no longer having suicidal ideation. The same day, a suicide prevention team staff inactivated the PRF in the patient’s EHR and alerted the clinical pharmacy specialist to the status of the PRF through the EHR. The patient attended psychotherapy sessions with the PTSD provider three times over the next four weeks.²⁹

Patient 4

Patient 4, who was in their 30s, presented to the clinic in early 2022 (Day 1) with no reported mental health history but a desire to start mental health services. The patient met with a nurse and a psychiatrist and reported stopping their own suicide attempt the day prior. The patient, who denied suicidal ideation at the time of the appointment, declined the offer of inpatient mental health admission but agreed to a scheduled follow-up contact with the psychiatrist for the next day. The psychiatrist documented the patient was at risk for suicide, and requested the suicide prevention team consider a PRF for the patient. The psychiatrist also documented submitting a BHIP consult, which was scheduled approximately one month later.

Day 2, the patient spoke with the psychiatrist and continued to decline inpatient mental health admission. Also, a suicide prevention team staff placed a PRF in the patient’s EHR and sent a letter to the patient describing the suicide prevention team’s role and providing contact information for the Veterans Crisis Line. On Day 3, the patient called the Veterans Crisis Line, reporting relationship problems, and accepted a referral to the suicide prevention team to obtain couples counseling resources. The same day, a suicide prevention team member called the patient and alerted the BHIP team through the EHR of the patient’s request for an earlier assessment.³⁰ Day 8, the patient called the clinic and spoke with a mental health nurse about ongoing anxiety. The patient also acknowledged awareness of the Veterans Crisis Line as a resource. The patient canceled the BHIP assessment scheduled that day, stating “it was not needed.” On Day 57 and Day 67, suicide prevention staff attempted to contact the patient but were unsuccessful and unable to leave voicemail messages. The OIG did not identify

²⁹ The patient continued in psychotherapy for PTSD past the OIG’s focused time frame.

³⁰ The patient’s EHR reflects that the BHIP team acknowledged the request for an earlier BHIP assessment.

documentation of further attempts by suicide prevention staff to contact the patient. On Day 87, due to the patient's lack of engagement in mental health treatment, a suicide prevention team staff inactivated the patient's PRF as there was "no evidence of acute suicidal ideation, intent, or behaviors."

Inspection Results

1. Delayed Access to Outpatient Mental Health Care

The OIG substantiated that access to mental health care was delayed related to BHIP and psychotherapy consult completion not meeting VHA's required time frame. The OIG reviewed a sample of EHRs with consult delays and did not identify any adverse clinical outcomes.³¹ However, the OIG recognizes delays in care may increase the risk of adverse clinical outcomes; therefore, the OIG would expect facility leaders to proactively mitigate delays in consult completion.

The OIG did not substantiate BHIP consults need to be completed prior to psychotherapy availability. However, the OIG found clinic providers did not fully understand the psychotherapy consult process; specifically, that providers could enter psychotherapy consults without a BHIP assessment if clinically indicated and if specialty mental health services could address the patient's needs.

To review for patient safety concerns and determine if adverse clinical outcomes occurred as a result of consult delays, the OIG reviewed the EHRs of 11 patients for episodes of care, described and provided by interviewed clinic providers. The OIG learned

- [Patient 1](#) and [Patient 2](#) had delayed psychotherapy consults,
- seven patients were alleged at risk for patient safety concerns due to provider workload burden; however, there were no risks or deficiencies identified in the care provided, and
- [Patient 3](#) and [Patient 4](#) did not receive required suicide prevention care.

Delays in BHIP and Psychotherapy Consults

VHA outpatient mental health care includes general mental health services, evidence-based psychotherapy, and other specialty mental health services, such as treatment for patients with

³¹ VHA Directive 1230(5), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended September 24, 2021. This directive was in place during the time of events discussed in this report. It was rescinded and replaced by VHA Directive 1230, *Outpatient Scheduling Management*, June 1, 2022. The new directive replaced the "Clinically Indicated Date" with "Patient Indicated Date." The PID "is the date the health care provider and Veteran agree is clinically indicated for care. In the absence of health care provider input, the PID is the Veteran's preferred date."

PTSD and military sexual trauma.³² VHA requires patients receive a comprehensive diagnostic and treatment planning evaluation within 30 days of referral or request for mental health care.³³

VHA requires every facility have at least one BHIP team that is composed of outpatient mental health providers and administrative support staff, who collaborate to offer patient services such as comprehensive evaluations and treatment planning.³⁴ A provider may refer a patient, via a mental health consult, for outpatient mental health services. The consult can be for a comprehensive evaluation by a BHIP team, referral to psychotherapy, or services provided by a specialty mental health program.³⁵ After the patient receives the requested services, the consult status is changed to “complete” in the EHR.³⁶ Per VHA, mental health consults must be completed within 30 days of the patient indicated date (PID).³⁷ If a mental health service is not immediately available, providers must monitor patients and implement alternative treatments, as appropriate.³⁸

Analysis of BHIP Consult Data

The OIG learned from the chief of Mental Health that BHIP consults were completed by licensed professional counselors for all patients new to the Mental Health Service. Each BHIP team meets weekly to discuss treatment recommendations from the completed assessments and when needed, submits consults for additional care, such as psychotherapy. Mental Health leaders told the OIG about tracking completion of BHIP consults to compare the completion time to the

³² VHA Handbook 1160.01(1), *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015; “Evidenced-Based Therapy,” (web page), VHA Mental Health, accessed October 20, 2022, <https://www.mentalhealth.va.gov/get-help/treatment/ebt.asp>. Evidence-based psychotherapies are mental health treatments that have shown improvement in a variety of mental health conditions; VHA MST Support Team, “Military Sexual Trauma,” May 2021. Military sexual trauma is a term VHA uses to reference “sexual assault or sexual harassment experienced during military service.” For this review, the OIG refers to evidenced-based psychotherapy as general psychotherapy, therapy for PTSD and military sexual trauma, as well as couples therapy.

³³ VHA Handbook 1160.01(1).

³⁴ VHA Deputy Under Secretary for Health for Operations and Management, “General Mental Health Staffing Model Team Development: Behavioral Health Interdisciplinary Program (BHIP) Team-Based Care,” memorandum to Network Directors, August 5, 2013; VHA Office of Mental Health Operations BHIP Implementation Team, “Behavioral Health Interdisciplinary Program (BHIP): Implementation Methodology,” May 2019. The facility has more than one BHIP team.

³⁵ VHA Handbook 1160.01(1).

³⁶ VHA Directive 1232(2), *Consult Processes and Procedures*, August 24, 2016, amended June 28, 2019. This directive was in place during the time of events discussed in this report. It was amended by VHA Directive 1232(3), *Consult Processes and Procedures*, August 24, 2016, amended April 5, 2021, VHA Directive 1232(4), *Consult Processes and Procedures*, August 24, 2016, amended December 14, 2021, and VHA Directive 1232(5), *Consult Processes and Procedures*, August 24, 2016, amended December 5, 2022. All directives contain the same or similar language for completed consults.

³⁷ VHA Handbook 1160.01(1); VHA Directive 1230(5); VHA Directive 1230.

³⁸ VHA Handbook 1160.01(1).

patient’s wait time for community mental health care and work with Mental Health supervisors to timely address consults.³⁹

The OIG analyzed 1,088 completed BHIP consults, submitted from November 1, 2020, through June 30, 2022 (see table 1).

Table 1. BHIP Consult Wait Times

| Consult Type | Median Days to Completion | % Completed Within 30 Days | % Completed Within 45 Days | % Completed Within 90 Days |
|--------------|---------------------------|----------------------------|----------------------------|----------------------------|
| BHIP | 25 | 59.5 | 82.4 | 97.6 |

Source: OIG analysis of time for BHIP consult completion in the clinic.

The OIG determined the median wait time for completion of a BHIP consult was 25 days from the PID.⁴⁰ The OIG found that 40.5 percent of BHIP consults did not meet the required completion time of 30 days from the PID.

When asked about not meeting the required time frame for consult completion, the working supervisor clinician of Primary Care Mental Health Integration (supervisor of PCMHI) and the former section chief of the clinic told the OIG that BHIP consults were delayed because there were many steps in the scheduling, assessment, and treatment planning processes. Additionally, the facility BHIP teams’ meetings do not function efficiently. Specifically, team meetings do not have a formal leader or a designated authority to direct treatment decisions.⁴¹ Furthermore, the chief of Mental Health and the Mental Health administrative officer stated one of the four positions for licensed professional counselors, who complete the BHIP consults, was vacant, which contributed to delays; however, wait times were expected to decrease upon filling the vacancy.⁴²

To further assess completion time frames, the OIG also looked at BHIP consult percentage completed at 45 and 90 days from the PID. Completion rates improved to 82.4 percent at 45 days and 97.6 percent at 90 days. Nonetheless, concerned that delays of 45 and 90 days may have

³⁹ Mental Health leaders included the chief of Mental Health and mental health administrative officer. VHA Acting Deputy Under Secretary for Health for Operations and Management, “Updated Stop Codes Used for 20 Day Wait Time Access Standard,” memorandum to VISN and Medical Center Directors, August 8, 2019. Veterans who are new patients are eligible for care in the community if facility appointment wait times are greater than 20 days.

⁴⁰ Merriam-Webster, “median,” accessed September 26, 2022, <https://www.merriam-webster.com/dictionary/median>. The median is a value in an ordered set of values in which there are an equal number of values below and above the median value. The OIG team used the median to measure the number of days until BHIP completion. The OIG selected median wait time over average wait time to reduce impact of outlying data points, which could skew wait times.

⁴¹ The supervisor of PCMHI does not attend the BHIP meetings, and the former section chief of the clinic no longer works at the facility and started at another facility on August 1, 2022.

⁴² On November 14, 2022, the chief of Mental Health informed the OIG that the licensed professional counselor vacancy was filled on October 23, 2022.

caused adverse clinical outcomes, the OIG reviewed a sample of patients’ EHRs for evidence of reasonable delays in scheduling, such as patient cancellation.⁴³ The OIG identified five patients whose consults did not reflect documentation of reasonable delays but there were no adverse clinical outcomes.

Additionally, the OIG considered consults not completed within or pending completion after 90 days of the PID to be an unreasonable time frame. The OIG reviewed 19 patients’ EHRs that met this criteria and found no adverse clinical outcomes.

Analysis of Psychotherapy Consult Data

The OIG analyzed data of 1,353 completed consults related to psychotherapy, PTSD, military sexual trauma, and couples therapy, submitted from November 1, 2020, through June 30, 2022 (see table 2).

Table 2. Psychotherapy Consult Wait Times

| Consult Type | Number of Completed Consults | Median Days to Completion | % Completed Within 30 Days | % Completed Within 45 Days | % Completed Within 90 Days |
|------------------------|------------------------------|---------------------------|----------------------------|----------------------------|----------------------------|
| General Psychotherapy | 726 | 19 | 60.7 | 73.3 | 96.7 |
| PTSD | 375 | 23 | 60.5 | 75.5 | 96.8 |
| Military Sexual Trauma | 137 | 15 | 73 | 86.9 | 97.1 |
| Couple's Therapy | 115 | 46 | 32.2 | 49.6 | 93 |

Source: OIG analysis of general psychotherapy, PTSD, military sexual trauma, and couples therapy consult wait times in the Outpatient Mental Health clinic. Data retrieved from VA Corporate Data Warehouse on September 5, 2022.

The OIG found the median wait times from the PID to psychotherapy consult completion was 19 days for general psychotherapy, 23 days for PTSD, 15 days for military sexual trauma, and 46 days for couple’s therapy (see table 2). The OIG found that 39.3 percent of psychotherapy, 39.5 percent of PTSD, 27 percent of military sexual trauma, and 67.8 percent of couple’s therapy consults did not meet the required completion time of 30 days from the PID.

To further assess completion time frames the OIG also looked at psychotherapy consult percentage completed at 45 and 90 days from the PID. Psychotherapy consult percentage rates

⁴³ The OIG selected 45 days as it was the 75th percentile for BHIP.

completed at 45 and 90 days from the PID improved with the additional time; specifically, couple's therapy, which increased 60.8 percent from 30 to 90 days completion.

Mental Health leaders told the OIG that psychotherapy consult delays occurred because

- staffing issues limit the number of providers who complete the consults;
- “assignments are based on availability, and if the therapists are backlogged” then patients must wait to start psychotherapy; and
- the Clinical Resource Hub, used for military sexual trauma psychotherapy, is no longer available due to Hub staffing concerns.⁴⁴

In addition to evaluating the psychotherapy consult completion rate concerns, clinic providers told the OIG about concerns for two patients, [Patient 1](#) and [Patient 2](#), who experienced delays between the indication of need for psychotherapy and psychotherapy consult completion. The OIG reviewed the patients' episodes of care in the EHR. The OIG did not find documentation of a psychotherapy consult in [Patient 1](#)'s EHR. A physician assistant submitted a BHIP assessment consult for treatment planning, which was scheduled for late summer 2021; however, the patient failed to show for the appointment. The BHIP consult was rescheduled for mid-fall but [Patient 1](#) died before the consult was completed. The OIG found that despite placement of a psychotherapy consult after a hospitalization for suicidal ideation, [Patient 2](#) waited 63 days from the PID for the consult to be completed. However, [Patient 2](#) had three Mental Health encounters during the 63-day time frame, including two medication management appointments.

Alleged Prohibition of Entering Psychotherapy Consults

The OIG did not substantiate prescribers were prohibited from entering psychotherapy consults prior to completion of a BHIP consult. However, the OIG found prescribers, including the former section chief of the clinic, were unaware that psychotherapy consults could be submitted independent of the BHIP consult process.

VHA specialty mental health services include consultation or referral for psychotherapy, which a provider can request via a consult in the patient's EHR once the provider determines a patient needs further treatment.⁴⁵ The OIG did not find a VHA policy that specifically states BHIP team approval is required prior to entering a mental health consultation for specialty care. VHA encourages streamlined processes for patients to ensure open access to care, and when a patient's

⁴⁴ Mental Health leaders include the former section chief of the clinic, the mental health psychology section chief, and the chief of Mental Health. “Clinical Resource Hubs (CRH)” (web page), VHA Patient Care Services, accessed December 12, 2022, <https://www.patientcare.va.gov/primarycare/CRH.asp>. VHA Clinical Resource Hubs are operated by the VISN and provide direct care (primarily through telehealth) to patients, such as mental health treatment, “when local facilities have gaps in care or service capabilities.”

⁴⁵ VHA Handbook 1160.01(1).

needs can be addressed by a specialty Mental Health program, an assignment to a BHIP team is not necessary.⁴⁶

A complainant alleged that [Patient 1](#) “asked for therapy and did not get it because [the patient] would need a BHIP assessment first.” The chief of mental health told the OIG that providers may submit a consult for psychotherapy at any time for patients established in Mental Health.

The OIG learned the majority of the prescribers interviewed believed that “permission” from the BHIP team was required before placing a psychotherapy consult in a patient’s EHR, for new and established patients.⁴⁷ The OIG inquired why prescribers might have this mistaken belief and was told by the Psychology Services chief section lead for outpatient Mental Health (mental health psychology section chief), that a psychologist inaccurately described a psychotherapy consult as requiring team approval during a BHIP team meeting.⁴⁸ In response to learning of this misconception, the mental health psychology section chief sent an email outlining the correct process to the former section chief of the clinic, but the OIG did not find evidence this information was then shared with prescribers.

During the inspection, the OIG found that after receiving the email, the former section chief of the clinic continued to believe that providers must go through the BHIP team to refer patients for psychotherapy. When the OIG asked if it would be surprising that prescribers still believe approval from the BHIP team is required before placing a psychotherapy consult, the mental health psychology section chief responded, “It would not.” Adding, “I don’t think the communication [in]. . . the clinic has been very good.”

Leaders’ Response

The OIG found that Mental Health leaders were aware of BHIP consult delays and initiated HRO process improvements. However, the OIG determined that Mental Health leaders’ response to clarify the psychotherapy consult process was deficient and led to misunderstandings among providers seeking care for their patients.

The OIG reviewed the facility leaders’ response to the concerns in the context of HRO principles related to process improvement, communication, and patient safety. Additionally, the OIG applied VHA and The Joint Commission expectations that leaders communicate clearly and regularly with staff and each other regarding issues that pose a risk to patient safety.⁴⁹

⁴⁶ VHA Office of Mental Health Operations BHIP Implementation Team, “Behavioral Health Interdisciplinary Program (BHIP): Implementation Methodology.”

⁴⁷ Prescribers interviewed included psychiatrists, physician assistants, and clinical pharmacy specialists. Two prescribers described placing psychotherapy consults for patients without prior approval from the BHIP team.

⁴⁸ The mental health psychology section chief manages the clinic psychotherapy consults.

⁴⁹ “VHA High Reliability Organization (HRO) Reference Guide” (web page), VHA; *Standards Manual*, LD.03.01.01, July 2021 and January 2022; *Standards Manual*, LD.02.03.01, July 2021 and January 2022.

To decrease the number of days a patient waits for BHIP and psychotherapy consults to be completed, the facility started a process improvement project on March 21, 2022. The project's charter states "[d]ue to staffing vacancies and delays in access, Veterans are assigned to [the] first available provider regardless of the team assignment which has created cross team care and continues to contribute to delays in access."⁵⁰ Additionally, the OIG learned that the facility volunteered for, and was selected as, the VISN's pilot site for the VHA BHIP expansion initiative. The initiative uses the BHIP-Collaborative Chronic Care Model to promote improved team function, comprehensive and accessible mental health services, and ensures adequate staffing.⁵¹

Upon learning of the clinic providers' misunderstanding of the psychotherapy consult process and differing accounts of psychotherapy resources, the OIG asked the facility leaders to educate clinic staff about the process for psychotherapy consultation and update staff on the status of the Clinical Resource Hub. On August 8, 2022, the chief of Mental Health sent an email to all clinic staff stating

- "[s]taff are not in any way prohibited from placing any type of consult that a provider determines is necessary for Veteran care," and
- that although the contract for psychotherapy assistance expired, Mental Health has reapplied for assistance through the Clinical Resource Hub.

The OIG concluded that clinic providers were not restricted when entering psychotherapy consults. Delays in psychotherapy care were attributed to the lack of available therapy providers and unclear communication regarding the psychotherapy consult process. Additionally, the OIG found Mental Health leaders responded to delays in BHIP consults through ongoing process improvement that highlighted deficiencies but did not clearly communicate with each other or the clinic staff to address ongoing misperceptions about the psychotherapy consult process or resources to avoid further delays in care. The OIG concluded that these failures in communication delayed referral for timely mental health evaluations.

2. Prescriber Turnover in the Outpatient Mental Health Clinic

The OIG substantiated prescribers left the clinic due to their concerns regarding patient safety issues, workload burden, and burnout. The OIG did not identify patient safety issues. The OIG

⁵⁰ Facility Process Improvement Charter, "Mental Health Access Measures - Access," March 21, 2022. The workgroup planned to first meet on July 18, 2022, and to continue work in August and September.

⁵¹ VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO), "Expanded Implementation of Outpatient Behavioral Health Interdisciplinary Program-Collaborative Chronic Care Model (BHIP-CCM) Team-Based Care," memorandum to VISN Directors and Chief Medical, Nursing, and Mental Health officers, June 28, 2022. This memorandum outlined the initiative, stating all facilities (VA medical centers and community-based outpatient clinics) must transition outpatient Mental Health care to the BHIP-CCM model over the next five years.

found some prescribers interviewed cited workload burden and burnout as reasons for leaving. The OIG determined the facility did not have processes to ascertain why staff leave and to inform retention strategies, which are necessary to maintain staffing levels for accessibility to patient care.

A study published in *Psychiatric Services* examined the relationship between VHA's outpatient mental health staffing model and the quality of and access to treatment.⁵² The study found that staffing should be a primary consideration for facilities to improve care. Moreover, staff turnover was linked to burnout as “[p]roviders experiencing burnout. . . are more likely to leave their positions.”⁵³ Another study found burnout is associated with “poor patient safety outcomes.”⁵⁴

VHA's outpatient mental health staffing model focuses, in part, on having enough staff to ensure accessible and continuous patient care, and “ensure continuity and intensity of treatment during an episode of care.”⁵⁵ VHA suggests facility leaders “strategically plan to address gaps” in staffing to meet the demand for care and the required staffing levels.⁵⁶

The OIG reviewed prescriber staffing at the clinic from November 2020 through June 2022, and found four prescribers left the clinic. One psychiatrist and one physician assistant transferred within the facility (to inpatient Mental Health and the Substance Use Disorder clinic, respectively), one psychiatrist resigned from the VA, and one physician assistant transferred to another VA facility (see figure 1). The OIG analyzed the vacancies over the 20-month period reviewed and noted the vacancy rate ranged from 9 to 36 percent.

⁵² Matthew Tyler Boden et al., “Mental Health Treatment Quality, Access, and Satisfaction: Optimizing Staffing in an Era of Fiscal Accountability,” *Psychiatric Services* 70, (March 2019): 168-175.

⁵³ Substance Abuse and Mental Health Services Administration (SAMHSA), *Evidenced-Based Resource Guide Series*, “Addressing Burnout in the Behavioral Health Workforce Through Organizational Strategies,” accessed November 14, 2022, https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep22-06-02-005.pdf, p. 1.

⁵⁴ Louise H. Hall et al., “Healthcare Staff Wellbeing, Burnout, and Patient Safety: A Systematic Review,” *PLOS One* 11(7), (July 8, 2016), pp. 2.

⁵⁵ VHA Directive 1161, p. A-4.

⁵⁶ VHA Directive 1161, p. A-4.

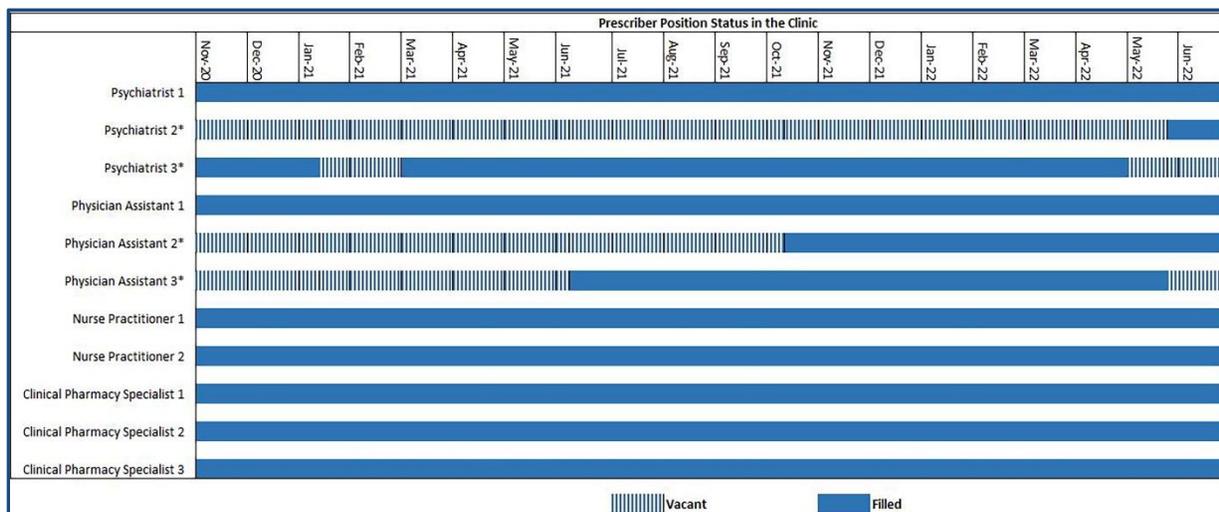


Figure 1. Prescriber Position Status in the Clinic.

Source: Facility Mental Health Vacancy Tracker, November 1, 2020, to June 30, 2022

Note: The dates with an asterisk in the above figure represent approximations of dates vacant or filled.

VHA uses a system that captures point-in-time data for staff gains and losses but does not track Mental Health staff at a specific clinic or staff position levels in a uniform way. Therefore, the OIG could not determine if prescribers left the clinic at a higher or lower rate compared to other VHA facilities’ mental health staff. However, the Chief of Staff expressed to the OIG having no knowledge that prescribers are leaving the Mental Health Service “at any greater rate or speed” than other services.

The OIG interviewed three of the four prescribers that left the clinic and all three described a work environment that lacked support from other clinic providers, such as psychologists and social workers, creating an overburden of work.⁵⁷ One prescriber told the OIG “I worked all those hours but that’s not sustainable,” and explained wanting to spend more time with family. All prescribers described a workload burden that led them to be concerned about patient safety, but did not identify specific patient safety issues. Additionally, one prescriber told the OIG that the concern for patient safety, and the belief that prescribers were leaving or looking for other jobs, was reported to the former section chief of the clinic. When the OIG asked the former section chief about prescribers’ concerns with patient safety in the clinic, the response was that the term patient safety was “somewhat of a moniker for being overworked” and did not feel there were patient safety issues.

Clinic providers gave the OIG a list of seven patients whose care may have prompted patient safety concerns due to provider workload burden. To determine whether risks to patient safety were present, the OIG reviewed the patients’ episode of care in the EHR, as described by the

⁵⁷ The OIG interviewed staff within the outpatient Mental Health setting and elected to not interview the psychiatrist who transferred to inpatient Mental Health for administrative reasons unrelated to this inspection.

provider, for support of the alleged care concerns. The OIG found care was appropriate and did not identify patient safety risks.⁵⁸

The OIG also reviewed the fiscal year 2022 All Employee Survey clinic response to determine whether prescribers reported concerns similar to those reported to the OIG. Of the nine prescribers who completed the survey

- seven reported planning to leave within the next year, and
- eight reported experiencing physical, emotional, or cognitive burnout.⁵⁹

Prescribers noted reasons for their intent to leave included workload and burnout, unhappiness with leadership or direction of the organization, and lack of work life balance.

On May 6, 2022, facility leaders told the OIG regarding Mental Health staff leaving, “[m]ost resignations over the last 18 months were related to the [COVID-19] pandemic, not any internal factors, which has been confirmed in exit interviews.” However, the OIG learned from the chief of Mental Health that formal exit interviews were not conducted. When the OIG asked for the exit interviews referenced in the May response to the OIG, the chief of Mental Health stated, “I do not have any documentation to provide.” The Facility Director told the OIG that they learn of staff reasons for leaving from communications such as emailed resignations, and reported the intention to conduct exit interviews in the future.

The OIG concluded that although the facility leaders believed most clinic staff resignations were a result of the COVID-19 pandemic, prescribers reported leaving the clinic due to concerns about patient safety issues, perceived workload burden, and burnout. These concerns can lead to gaps in staffing and possible delays in care. However, the OIG did not identify patient safety concerns

⁵⁸ The OIG also reviewed the Mental Health service’s Joint Patient Safety Reports from November 1, 2020, through June 30, 2022, and did not find reports related to provision of care in Mental Health. The Joint Patient Safety Reporting System is the VHA’s patient safety event reporting system and database. “Frequently Asked Questions” (web page), VHA National Center for Patient Safety, accessed September 30, 2022, <https://www.patientsafety.va.gov/about/faqs.asp>.

⁵⁹ The OIG did not review survey results for fiscal years 2020 (from October 1, 2019, through September 30, 2020) and 2021 (from October 1, 2020, through September 30, 2021) as the responses were not specific to the prescribing staff; “AES Survey History,” VHA National Center for Organization Development, https://dvagov.sharepoint.com/sites/VHAAES/Shared%20Documents/04_AES_History_Concepts.pdf#search=annual,p.1. (This website is not publicly accessible.) The All Employee Survey “is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential.” Survey results provide leadership information for a range of efforts from action planning to serving as a feedback tool; “2022 VA All Employee Survey (AES),” VHA National Center for Organization Development, https://dvagov.sharepoint.com/:w:/r/sites/AESHelpDesk/_layouts/15/Doc.aspx?sourcedoc=%7BF6550A11-35BB-42E5-8C0A-CED3A6D18C95%7D&file=2022%20AES%Instrument-%20Questions%20by%20Theme.docx&action=default&mobileredirect=tru&DefaultItemOpen=1. (This website is not publicly accessible.) The All Employee Survey defines physical burnout as exhaustion from work, emotional burnout as worry to become emotionally hardened from their job, and cognitive burnout as the feeling unaccomplished in work.

in the care for the list of patients provided by clinic providers; nor did the OIG identify relevant patient safety reports.

OIG Review of Mental Health Staffing

The OIG reviewed facility clinic staffing levels and recruitment efforts, which is a component of accessible care, to determine compliance with VHA requirements and to learn how facility leaders addressed identified staffing needs. The OIG found that although the minimum required full-time equivalent (FTE) employee staff was met, the Facility Director reported critical clinical shortages in the Mental Health Service; specifically, psychology and substance use disorder nurse practitioners for fiscal year 2022, and the Mental Health Service faces challenges in recruiting providers.⁶⁰

To ensure timely access to care, VHA recommends a minimum of 7.72 outpatient clinical FTE for every 1,000 patients receiving mental health care.⁶¹ Additionally, VHA designates facilities in “critical” need of staff when the outpatient staff-to-patient ratio falls below 6 FTE per 1,000 patients.⁶²

The OIG reviewed staffing data for the clinic from November 2020 through June 2022, and found the facility met the required staffing ratio. However, the clinical FTE in the clinic had declined from 9.73 FTE in quarter 3 of fiscal year 2021 to 8.3 FTE in quarter 3 of fiscal year 2022 (see figure 2).

⁶⁰ VA OIG, *OIG Determination of Veterans Health Administration’s Occupational Staffing Shortages: Fiscal Year 2022*; VHA Directive 1161, p. 2 “Full Time Equivalent Clinical (FTE(c)) is the portion of a full-time equivalent employee (removing leave) which is devoted to clinical, direct patient care.”

⁶¹ VHA Directive 1161.

⁶² VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO), “Eliminating Veteran Suicide: Enhancing Mental Health Staffing,” memorandum to the Veterans Integrated Services Network (VISN) Directors and Medical Center Directors, January 26, 2021, p. 1. This memorandum was in place during some of the time of the events discussed in this report. It was replaced by VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO), “Eliminating Veteran Suicide: Enhancing Mental Health Staffing,” memorandum to the Veterans Integrated Service Network (VISN) Directors and Medical Center Directors, March 19, 2021, p. 1, and subsequently VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO), “Eliminating Veteran Suicide: Enhancing Mental Health Staffing,” memorandum to the Veterans Integrated Services Network (VISN) Directors and Medical Center Directors, February 9, 2022, p. 1. All memorandums contain the same or similar language.

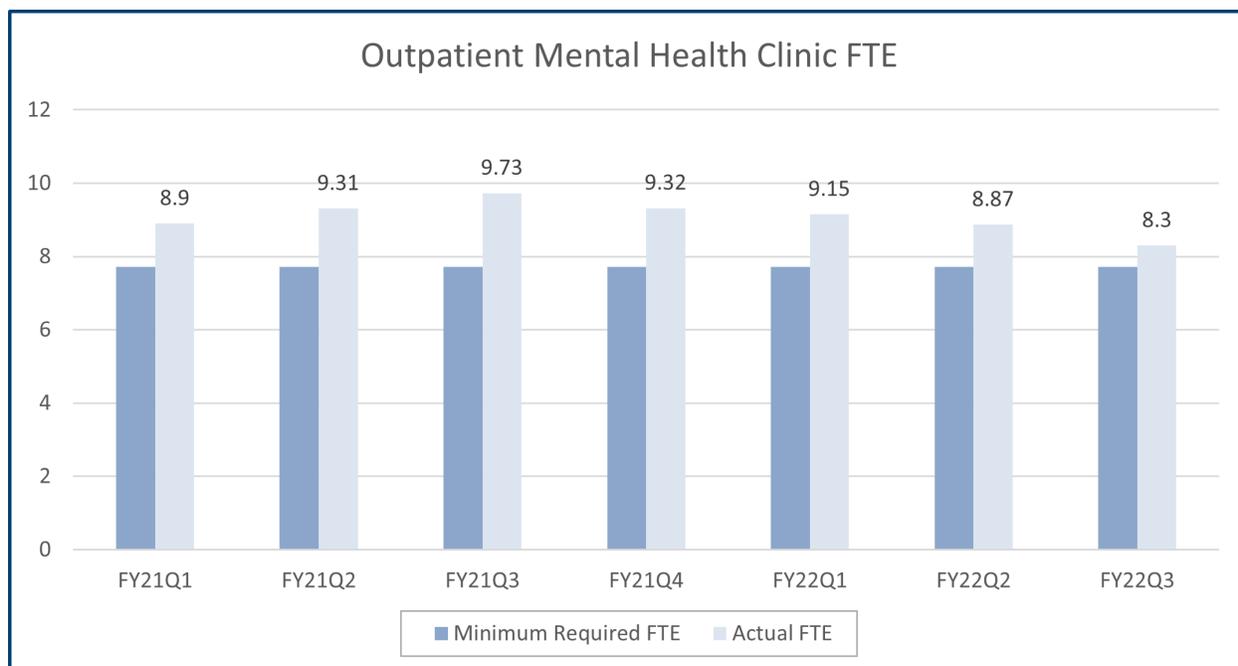


Figure 2. Staffing in the Clinic.

Source: OIG analysis of all FTE from VHA’s Office of Mental Health and Suicide Prevention Mental Health Staffing and Productivity Dashboard, November 1, 2020, to June 30, 2022.

Note: Fiscal year 2021 started on October 1, 2020, and ended September 30, 2021, and fiscal year 2022 started on October 1, 2021, and ended September 30, 2022. Each quarter is three months.

The OIG recognizes that VHA outpatient mental health staffing must also include enough staff to provide accessible mental health care, and facility leaders should address identified gaps in staffing to ensure accessible mental health services.⁶³ The OIG found despite meeting minimum VHA staffing requirements for outpatient mental health, in a July 2022 OIG report, the Facility Director reported 13 clinical positions, including psychology and substance use disorder nurse practitioners, as having shortages for fiscal year 2022.⁶⁴

Leaders’ Response

The goal of VHA’s “Journey to High Reliability” is to transform workplace culture by engaging and empowering staff to provide high quality and safe patient care. Leaders may achieve this transformation by encouraging individual and team improvements.⁶⁵ Additionally, in January

⁶³ VHA Directive 1161.

⁶⁴ VA OIG, *OIG Determination of Veterans Health Administration’s Occupational Staffing Shortages Fiscal Year 2022*.

⁶⁵ “VHA High Reliability Organization (HRO) Reference Guide” (web page), VHA.

2021, to ensure timely access to care through mental health staffing, VHA directed facilities to allow immediate recruitment for mental health vacancies.⁶⁶

In mid-March 2022, prescribers filed a union complaint that outlined “concerns over mounting clinical demands,” such as an overburden of work, as the “[m]ental health prescribers are the only mental health providers available for same-day access services.”⁶⁷ The OIG learned from the former section chief of the clinic that although generally aware that prescribers felt “overworked,” there were no discussions about the concerns outlined in the mid-March 2022 union complaint.

The chief of Mental Health told the OIG of initiating meetings to focus on process improvement with the prescribers, the former section chief of the clinic, and the associate chief of Pharmacy, once aware of prescriber’s reported overburden of work.

On May 2, 2022, and in response to the union complaints, Mental Health leaders initiated a process whereby licensed professional counselors triaged all patients in the same-day access clinic, helping to alleviate prescribers from the duty of seeing patients that do not require medication management. The chief of Mental Health told the OIG that same-day access clinic utilization data is manually tracked to determine whether the temporary use of licensed professional counselors in the same-day access clinic should be a permanent addition.⁶⁸ The OIG reviewed the same-day access clinic utilization data from May through July 2022, which showed for each month

- approximately 45 patients received care from the clinic,
- medication management accounted for more than 60 percent of patients’ needs, and
- licensed professional counselors provided care less than 30 percent of the time, as compared to prescribing staff at more than 70 percent.⁶⁹

⁶⁶ VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO), “Eliminating Veteran Suicide: Enhancing Mental Health Staffing,” memorandums.

⁶⁷ “Same Day Services in Primary Care and Mental Health” (web page), VA, accessed July 7, 2022, <https://www.va.gov/SAMEDAYSERVICES/index.asp>. All VA medical centers offer access to same-day mental health services for urgent needs, providing patients timely access to care when needed.

⁶⁸ The chief of Mental Health also told the OIG that in 2018, Mental Health Service reviewed the number of patients presenting to and the type of service requested from the same-day access clinic. During the two-month review, the licensed professional counselor saw six patients for non-medication management needs and the prescribing staff provided medication management for the remaining patients. At that time, Mental Health Service determined the position of a licensed professional counselor was not needed in the same-day access clinic.

⁶⁹ Same-day access clinic utilization data included care provided via telephone: 2 calls in May, 8 in June, and 10 in July 2022.

The chief of Mental Health told the OIG that upon becoming the chief of mental health, “my first order of business was to fill vacancies.”⁷⁰ Additionally, the Facility Director, Chief of Staff, and chief of Mental Health told the OIG that all Mental Health staff vacancies bypass the Resource Management Committee, and receive automatic approval for recruitment, as VHA requires.⁷¹

The OIG also inquired about difficulties with recruitment efforts. Facility leaders opined that

- western North Carolina has a scarcity of mental health providers and facilities,
- Asheville’s cost of living is high and the facility lacks locality pay to be competitive, and
- the facility lacks robust and well-established educational affiliates near the facility to recruit mental health providers.⁷²

Additionally, the Facility Director told the OIG of ongoing efforts to navigate these barriers by requesting a locality pay adjustment, as well as implementing hiring incentives when applicable, such as recruitment and retention pay, and telework.⁷³ Furthermore, the former section chief of the clinic told the OIG of a new educational cooperative to recruit Mental Health physicians.

The OIG determined that although the Mental Health Service leaders have engaged in process improvements to address prescribers’ perceived workload burden and to backfill clinic position vacancies as required by VHA, the service lacks an organized process to evaluate why prescribers leave, which would likely aide leaders in staff retention. In addition, the OIG found there are gaps in staffing, which facility leaders continue to address through recruitment efforts.

3. Prescribers’ Scope of Practice

The OIG did not substantiate prescribers were providing care outside of their scope of practice. The OIG reviewed requirements for prescribers with varying credentials, and found they practiced within their privileges or scopes of practice, as applicable.

⁷⁰ Prior to January 31, 2021, the chief of Mental Health was the assistant chief of Mental Health. The facility Mental Health vacancy tracker showed the position of assistant chief of Mental Health converted to the position of the mental health psychology section chief upon becoming vacant in January 2021.

⁷¹ The Facility Director told the OIG that the Resource Management Committee, which the facility calls the Resource Allocation Committee, approves new positions and provides approval for staff hired into those positions.

⁷² “Policy, Data, Oversight: Pay & Leave” (web page), Office of Personnel Management, accessed October 24, 2022, <https://www.opm.gov/policy-data-oversight/pay-leave/pay-systems/general-schedule/>. Locality pay is a “geographic-based percentage rate that reflects pay levels for non-Federal workers in certain geographic areas as determined by surveys conducted by the U.S. Bureau of Labor Statistics;” Additionally, the Chief of Staff told the OIG there are educational affiliations, but the majority are specific to mental health nurse practitioners.

⁷³ Following the OIG’s interview with the Facility Director, the facility received a denial for the requested locality pay in August 2022. The facility’s disparity in pay as compared to the community was determined as 3.5 percent and did not meet the required amount of 10 percent. Federal Salary Council, *Report of the Federal Salary Council Working Group*, August 5, 2022.

Credentialing is a systematic process of screening and evaluating a provider’s qualifications and other credentials including licensure, required education, and relevant training and experience. Privileging refers to the process of approving a provider’s procedures and services. VHA requires clinical privileges be facility, service, and provider specific and are based on “clinical competence as determined by peer references, professional experience, health status, education, training, and licensure.”⁷⁴

VHA requires that facilities establish medical bylaws that outline privileging procedures.⁷⁵ The facility’s medical bylaws state healthcare providers who are not physicians, “function under defined clinical privileges or a defined scope of practice.”⁷⁶ Specifically,

- physicians and advanced registered nurse practitioners “will be credentialed and privileged to practice independently,” and,
- physician assistants and clinical pharmacy specialists are “credentialed through the medical staff process” and “practice under a scope of Practice with appropriate supervision.”⁷⁷

⁷⁴ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012, p. 1. This handbook was in place during the time of the events discussed in this report. The credentialing portion of this handbook was superseded by VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021. Both documents contain the same or similar language about clinical privileges.

⁷⁵ VHA Handbook 1100.19.

⁷⁶ VHA Handbook 1100.19. VHA Western North Carolina VA Healthcare System Asheville, NC, *Bylaws of The Medical Staff*, January 16, 2020, was in effect during some of the OIG’s inspection period. It was replaced by VHA Western North Carolina VA Healthcare System Asheville, NC, *Bylaws of The Medical Staff*, December 2021, and subsequently the VHA Western North Carolina VA Healthcare System Asheville, NC, *Bylaws of The Medical Staff*, March 2022. Unless otherwise specified, the requirements in the 2022 bylaws contain the same or similar language as the replaced 2021 and 2020 bylaws.

⁷⁷ Advanced Practice Registered Nurses, which include nurse practitioners, APRNs “treat and diagnose illnesses, advise the public on health issues, manage chronic disease, and engage in continuous education to remain ahead of any technological, methodological, or other developments in the field. [Advanced Practice Registered Nurses] hold at least a Master’s degree, in addition to the initial nursing education and licensing required for all Registered Nurses.” “Advanced Practice Registered Nurse (APRN)” (web page), American Nurses Association, accessed April 19, 2023, <https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/aprn/>; Facility, *Bylaws of The Medical Staff*.

The OIG reviewed prescribers' clinical privileges and scopes of practice:

- Psychiatrists, physician assistants, and nurse practitioners may treat and manage patients with acute and chronic mental health illness, and care for patients in a mental health crisis.
- Psychiatrists and physician assistants may provide therapy, while nurse practitioners may provide counseling for preventive care, medical conditions, and treatments.
- Clinical pharmacy specialists may provide medication management, develop therapeutic plans, and participate in interdisciplinary team planning.

In addition, the facility's service agreement between the Pharmacy and Mental Health Services states clinical pharmacy specialists cannot provide psychotherapy or diagnose patients, and should collaborate with psychiatry or other Mental Health providers when a patient requires care outside a pharmacy specialist's scope of practice.⁷⁸

During OIG interviews prescribers reported not practicing outside of privileges or scope, and the OIG did not find evidence that prescribers practiced outside of privileges or scope during the course of the inspection. The OIG learned from psychiatrists and physician assistants that there was not enough time to provide medication management and therapy in the same-day access clinic. Additionally, prescribers felt there was not enough support from psychologists, social workers, and therapists in the same-day access clinic. Specifically, clinical pharmacy specialists stated it was hard to find assistance for patients presenting with needs outside their scope of practice, which created pressure to provide care outside their scope of practice.⁷⁹

Leaders' Response

VHA HRO principles expect leaders to focus process improvements on work practices that impact patient care and reduce the risks of potential harm.⁸⁰ Additionally, The Joint Commission expects healthcare leaders to promote collaborative teamwork, which can be achieved through communication with fellow leaders.⁸¹

⁷⁸ Charles George VA Medical Center, Mental Health Pharmacist Provider (CPS) Care Coordination Agreement (CCA), August 15, 2019. Charles George VA Medical Center, Mental Health Clinical Pharmacy Specialist (MH CPS) Care Coordination Agreement (CCA), April 20, 2022. The service agreements contain similar language that require clinical pharmacy specialists to seek consultation from other Mental Health providers for patient needs extending beyond the scope of practice for clinical pharmacy specialists, and the April 2022 agreement encourages team collaboration for positive outcomes in patient care.

⁷⁹ In the mid-March 2022 union complaint, prescribers described the role of prescribers shifting from medication management to case management and therapy, causing clinical pharmacy specialists to provide services "out of their scope."

⁸⁰ "VHA High Reliability Organization (HRO) Reference Guide" (web page), VHA.

⁸¹ *Standards Manual*, LD.03.01.01, July 2021 and January 2022; *Standards Manual*, LD.02.03.01, July 2021 and January 2022.

The OIG learned that prescribers raised the concern to facility leaders about the potential risk of clinical pharmacy specialists practicing outside of their scope due to increased patient care needs. The facility leaders responded through operational changes in the same-day access clinic. However, the OIG found facility leaders did not demonstrate effective communication as responses were not timely or collaborative.

The chief of Mental Health was aware of the concerns that focused on process improvement through the March 2022 union complaint and told the OIG about meetings with the prescribers, the former section chief of the clinic, and the associate chief of Pharmacy. As a result of the meetings, clinical pharmacy specialists were removed from providing same-day access clinic services on May 2, 2022.

Additionally, the OIG found the role of clinical pharmacy specialists was clarified through a renewed service agreement between Mental Health and Pharmacy Service lines; as well as a mid-July 2022 email from the chief of Mental Health to all clinic providers and administrative staff, explaining clinical pharmacy specialists “are not scoped for psychotherapy.”⁸² However, the OIG learned from the chief of Mental Health the email was sent roughly three months after the leaders’ determined clarification was needed. The delay was due to a miscommunication about who would send the email.⁸³

The OIG asked the associate chief of Pharmacy about clinical pharmacy specialists continued concerns about practicing outside of their scope. The associate chief of Pharmacy stated the service agreement outlines the process, deferring to Mental Health Service procedures and “decision amongst that team” for questions of care coordination; and although the concerns within the union complaint had “[n]ot specifically” been raised to the chief of Pharmacy, there was “cursory, high-level awareness.”

The OIG concluded that Mental Health leaders made operational and workflow changes to the same-day access clinic and clarified the role of clinical pharmacy specialists. However, facility leaders struggled to uphold The Joint Commission standards of communication among Service-line leaders. VHA guidance states prompt and collaborative communication is essential to upholding a culture for safe and quality patient care.⁸⁴ The OIG found Mental Health leaders failed to promptly clarify the role of clinical pharmacy specialists and the associate chief of Pharmacy did not directly communicate with the chief of Pharmacy about the known concerns regarding scope of practice.

⁸² Facility care coordination agreements, 2019 and 2022.

⁸³ The miscommunication was between the chief of Mental Health and former section chief of the clinic.

⁸⁴ “VHA High Reliability Organization (HRO) Reference Guide” (web page), VHA.

4. Mental Health Leaders' Unclear Communication Regarding Use of Community Care Consults

The OIG substantiated facility Mental Health leaders discouraged clinic providers from entering community care consults by expressing the need to minimize expenses and maintain patient care at the facility. However, the OIG found clinic providers reported conflicting perceptions of Mental Health leaders' guidance, with some providers understanding community care consults as permissible and others believing consults were discouraged based on Mental Health leaders' guidance to minimize expenses and maintain patient care at the facility. Further, the OIG found providers did refer patients to community care.

VHA requires that when mental health care cannot be provided directly through VA, a patient may receive care in the community based on specific eligibility requirements, such as available services at VA; facility and community wait times; and patient travel time.⁸⁵ When scheduling staff are unable to schedule new or established patients for a mental health appointment at VA within 20 days, patients are eligible for care in the community and must be offered this option.⁸⁶

The OIG reviewed 461 mental health community care consults submitted between November 1, 2020, and June 30, 2022, and found an average of approximately 23 consults submitted per month. The OIG reviewed the consults and found nearly all the prescribers, as well as additional non-prescribing clinic providers, submitted community care consults during this time frame.

In interviews, the OIG heard conflicting information related to submitting community care consults. Two prescribers told the OIG that the chief of Mental Health told them it was important to keep patient care at the facility due to the expense of community care. However, two non-prescriber clinic providers stated community care consults had not been discouraged. The majority of the prescribers interviewed told the OIG that in addition to feeling discouraged to place community care consults, other reasons consults were not placed included the lack of available mental health care and long wait times in the community.

⁸⁵ VHA Handbook 1160.01(1); VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018) § 101; Patients are eligible for community care if average travel time to the facility is 30 minutes. VHA Office of Community Care, "Veteran Community Care: General Information," (fact sheet) September 9, 2019.

⁸⁶ VHA Acting Deputy Under Secretary for Health for Operations and Management, "Updated Stop Codes Used for 20 Day Wait Time Access Standard," memorandum; "VHA Office of Community Care Field Guidebook Chapter 2: Eligibility, Referral, and Scheduling," (website), VHA Office of Community Care, <https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx>. (This website is not publicly accessible.) This guidebook is continuously updated with new information. The most recent version is the "VHA Office of Integrated Veteran Care (IVC) Community Care Field Guidebook Chapter 2: Eligibility, Referral, and Scheduling," chap. 2 in *Field Guidebook*, updated April 18, 2023. Unless otherwise specified, chapter two of the 2023 guidebook contains the same or similar language regarding eligibility and offering of community care based on appointment availability.

The chief of Mental Health told the OIG that when scheduling staff contact patients to arrange requested facility mental health services and the wait time is over 20 days, the patient is offered community care and the patient's choice is documented in the EHR.⁸⁷ During the OIG review of BHIP and psychotherapy consults, there was evidence of the use of community care consults, indicating patients opted into community mental health care.

To determine whether patients complained about the lack of community care for mental health services, the OIG reviewed patient complaints regarding the clinic that were received by the facility from November 1, 2020, through June 30, 2022. The OIG found three complaints related to community care and upon review, determined the Mental Health Service resolved all three complaints.

When the OIG asked facility leaders why some clinic staff feel community care consults are discouraged

- the Chief of Staff said the message of using community care “could easily be misconstrued” and believed prescribers do not understand the consult process;
- the Mental Health psychology section chief explained that messages about community care have varied over the years as Mental Health leadership changed, noting the previous chief of Mental Health told staff to exhaust all other options before requesting community care; and
- the former section chief of the clinic reported some staff may feel discouraged in placing consults when services are available at the facility.⁸⁸

The chief of Mental Health told the OIG of sharing with all Mental Health staff the Mental Health business plan for fiscal year 2022 goal to “recapture veteran care.” The chief of Mental Health believed staff may have misunderstood the message, which was to bring patients back to the facility and provide care in-house but not prohibit care in the community. The chief of Mental Health also said that individual clinic staff who expressed a misunderstanding of care in the community were encouraged to place consults when eligibility criteria was met. However, when the OIG asked if all Mental Health staff were provided clarity on the purpose and consult process for community care, the chief of Mental Health said “no.”⁸⁹

⁸⁷ A medical support assistant supervisor in Care in the Community told the OIG that if a patient chooses community care, the consult is forwarded to Care in the Community for coordination of care in the community with a non-VA provider.

⁸⁸ The OIG did not interview the previous chief of Mental Health as the focus of the allegation was on current Mental Health leaders.

⁸⁹ After the OIG's onsite inspection, the chief of Mental Health provided clarification to all Mental Health staff that providers should submit community care consults as needed for patient care.

The OIG concluded that facility Mental Health leaders' message to "recapture veteran care" and maintain patient care at the facility may have contributed to some providers' believing that Mental Health leaders discouraged the use of community care consults to minimize expense. The OIG did not find Mental Health leaders prohibited the use of community care as clinic providers placed community care consults during the scope of review. However, providers may benefit from additional guidance on the use of community care consults. Additionally, the OIG found Mental Health leaders did not adhere to VHA HRO values regarding clear communication; leaders were aware of misperceptions but did not clarify with all staff the purpose and process for community care.

5. Alleged Lack of Assistance from the Suicide Prevention Team

The OIG did not substantiate that the suicide prevention team failed to support prescribers with clinical duties such as suicide risk evaluation, safety planning, crisis management, or post-hospitalization follow-up for clinic patients, including patients with a PRF.⁹⁰ The OIG identified a general misunderstanding by some prescribers about the role of the suicide prevention team.

VHA requires clinical staff to screen patients for suicidal risk and that providers complete safety plans using the Suicide Prevention Safety Plan EHR template in collaboration with patients to "maintain safety and regain equilibrium."⁹¹ Consistent with privileges and scopes of practice, psychiatrists, physician assistants, and nurse practitioners may treat and manage suicidal patients as well as provide mental health crisis intervention. Clinical pharmacy specialists are expected to complete suicide risk screenings and safety plans, but must collaborate with other Mental Health providers when a patient requires more specialized care such as inpatient hospitalization or referral for placement of a PRF.⁹²

Suicide prevention teams are responsible for PRF placement in the EHR and will manage enhanced care of patients with a PRF through coordination and consultation with VHA providers in an effort to prevent ongoing suicidality.⁹³ The suicide prevention team is required to ensure the patient completes four mental health follow-up appointments with a mental health provider

⁹⁰ At the time of the OIG's inspection, the facility's suicide prevention team consisted of two suicide prevention coordinators and two suicide prevention case managers.

⁹¹ VHA Deputy Under Secretary for Health for Operations and Management (DUSHOM), "Eliminating Veteran Suicide: Implementation of Suicide Risk Screening and Evaluation," memorandum to Veterans Integrated Service Network (VISN) Directors, VISN Mental Health Leads, and Medical Center Directors, November 2, 2018; VHA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide," p. 50. Safety plans are required for patients with a PRF, a recent suicide attempt, or admission to psychiatric or residential treatment.

⁹² Facility care coordination agreements, 2019 and 2022.

⁹³ VHA Directive 2008-036; VHA Directive 1160.07; VHA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide." Enhanced care "involves completing assessments of suicide risk, ensuring proper care is provided, and maintaining communications with Veterans following discharge from acute or residential care settings."

within 30 days of a PRF placement. Providers must complete and document a safety plan within seven days of the PRF placement by the suicide prevention team.⁹⁴ The suicide prevention team monitors this follow-up using VHA's High Risk Flag Patient Tracking Report Dashboard.⁹⁵

VHA Office of Mental Health and Suicide Prevention recommends that suicide prevention teams focus 90 to 100 percent of staff's time on administrative work to carry out program requirements. Although this recommendation does not prevent a suicide prevention team from providing clinical care, VHA Office of Mental Health and Suicide Prevention notes, a suicide prevention team "generally focus[es] on oversight and monitoring, rather than providing direct patient care."⁹⁶ The facility policy requires the suicide prevention team provide "supplemental" care, such as telephone contacts if the patient is not keeping scheduled appointments, to patients with a PRF.⁹⁷

Facility Mental Health leaders explained to the OIG that the role of the suicide prevention team is to monitor and advise providers in the care of suicidal patients.⁹⁸ The Mental Health psychology section chief and the former section chief of the clinic specified the assigned provider is responsible for management and care for a suicidal patient, including the completion of suicide screenings, safety plans, and post-hospitalization follow-up. Mental Health leaders told the OIG, in addition to consultative services, the suicide prevention team may provide direct clinical services to support high-risk patients.⁹⁹

The OIG interviewed several prescribers and noted a lack of understanding about the suicide prevention team's role, including

- an unawareness that the suicide prevention team's duties are primarily administrative, such as oversight and monitoring of care provided rather than providing care directly;
- a frustration that the suicide prevention team is not more available for clinical assistance and can "delegate responsibilities" for suicidal patients to the prescriber; and

⁹⁴ VHA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide;" VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO), "Update to High Risk for Suicide Patient Record Flag (HRS-PRF) Changes," memorandum. This memorandum clarified that a safety plan must be completed within seven days of a PRF.

⁹⁵ VHA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide." The High Risk Flag Patient Tracking Report Dashboard tracks VHA required follow-up care for patients with a PRF, such as when the safety plan is completed and the number of mental health visits completed within 30 days of flag placement.

⁹⁶ VHA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide," p. 48.

⁹⁷ Charles George VA Medical Center Memorandum 637-116-11, *Suicide Assessment, Intervention, and Documentation*, August 2019, amended August 2020, p. 6.

⁹⁸ Mental Health leaders include the chief of Mental Health, the mental health psychology section chief, the former section chief of the clinic, and the social work supervisor in mental health.

⁹⁹ Mental Health leaders include the former section chief of the clinic, the Social Work supervisor in Mental Health, and the supervisor of PCMH.

- a belief that the suicide prevention team is primarily responsible for the outreach and management of suicidal patients or patients with a PRF.

The OIG concluded that lack of understanding regarding the role of the suicide prevention team led to some confusion among prescribers. The failure of Mental Health leaders to communicate providers' responsibilities regarding the management of suicidal or at risk of suicide patients could result in missed interventions or enhanced care protocols and lead to patient safety concerns or continued suicidality.

OIG EHR Review for High Risk for Suicide Patients

The OIG determined the suicide prevention team failed to monitor and manage VHA-required follow-up care for two patients with PRFs.¹⁰⁰ The OIG received the names of two patients, [Patient 3](#) and [Patient 4](#), from clinic providers alleging patient care did not meet VHA suicide prevention requirements. The OIG reviewed each patient's episode of care in the EHR, as defined by the clinic provider, and found

- [Patient 3](#) and [Patient 4](#) did not complete four appointments within 30 days of the PRF placement in the EHR,
- [Patient 3](#) did not receive a completed safety plan using the required EHR template within seven days of the PRF placement, but
- neither patient experienced adverse clinical outcomes as a result of failed suicide prevention efforts.

The OIG found that although [Patient 3](#) exchanged secure messages with the clinical pharmacy specialist during the 30 days following placement of the PRF in the patient's EHR, the patient did not have a mental health appointment.¹⁰¹ EHR documentation notes the patient received "informal although thorough safety planning;" however, a facility suicide prevention coordinator told the OIG that the management of [Patient 3](#) was a "fail;" as the patient did not receive required follow-up care or a completed safety plan using the required EHR template. The OIG

¹⁰⁰ The OIG did not review all patients with a PRF but reviewed those patients identified in complainant allegations and interviews during the inspection.

¹⁰¹ VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO) memorandum, "Update to High Risk for Suicide Patient Record Flag (HRS-PRF) Changes." This memorandum does not include secure messaging as an approved appointment modality; A suicide prevention team staff attempted to call the patient on March 17, 2022, but was unsuccessful in making contact and left a voicemail; Charles George VA Medical Center MHS-609, "Management of High Risk for Suicide Patient Record Flags" (standard operating procedure), March 10, 2022. As of March 10, 2022, the facility developed a standard operating procedure for management of a patient with a PRF that states the patient's treatment team must provide follow-up visits after placements of the PRF. However, the procedure does not assign the responsibility of making these appointments to any particular staff.

learned the suicide prevention team did not follow up with the provider, a clinical pharmacy specialist, to ensure a safety plan was completed using the required EHR template.

The suicide prevention coordinator explained to the OIG that required follow-up appointments are manually tracked by the team on a spreadsheet; however, for [Patient 3](#) the appointments entered in the spreadsheet did not match the appointments in the EHR. When asked if the suicide prevention team uses the VHA's High Risk Flag Patient Tracking Report Dashboard to monitor required follow-up for PRFs, the suicide prevention coordinator noted the suicide prevention team does review the dashboard and should have identified the missed appointments.¹⁰²

The OIG requested facility leaders ensure a review of the care and management for [Patient 3](#) was completed. The chief of Mental Health and a suicide prevention coordinator reviewed the episode of care and the circumstances relevant to the PRF and informed the OIG that in the initial 30 days following the placement of the PRF, the patient was difficult to reach due to the patient's work schedule. However, the patient re-engaged in mental health services following the initial 30 days and the patient's PRF was inactivated after the patient's Mental Health providers determined the risk of suicide had decreased.

[Patient 4](#) completed three of the four required mental health appointments within 30 days of the PRF placement in the EHR. Although the OIG did not find a fourth appointment scheduled for the patient, the OIG determined [Patient 4](#) did not experience an adverse clinical outcome as a result of not meeting suicide prevention follow-up requirements. Additionally, the patient was aware of, and utilized, available crisis resources such as the Veterans Crisis Line and the ability to call the clinic directly to speak with a mental health nurse. Based on the patient's self-reported improvement and decline for further mental health care, the OIG concluded follow-up review was not required.

The OIG concluded the suicide prevention team did not ensure required follow-up for two patients with PRFs. The OIG did not identify adverse clinical outcomes; however, opportunities to address the patients' heightened suicidal risk were missed.

Leaders' Response

The OIG determined that the Mental Health Service leaders reeducated Mental Health staff about care responsibilities to suicidal patients, including those with a PRF, but did not uphold the HRO value of clear communications when responding to staff concerns.

VHA expects leaders to model HRO values, such as providing clear communication and "listen[ing] and respond[ing] to the concerns staff members raise."¹⁰³ The OIG found the

¹⁰² The chief of Mental Health and a suicide prevention coordinator informed the OIG that the suicide prevention team checks VHA's High-Risk Flag Patient Tracking Report Dashboard daily.

¹⁰³ "VHA High Reliability Organization (HRO) Reference Guide" (web page), VHA.

referenced union complaint included concerns that the suicide prevention team did not assist with high risk for suicide patients presenting to the same-day access clinic. The Chief of Staff told the OIG of becoming aware of this concern in March and believed providers required reeducation about their suicide prevention care responsibilities. Further, the Chiefs of Staff and Mental Health have the duty “to tell everybody that it was their job.”

On July 7, 2021, the chief of Mental Health required staff who complete suicide risk assessments, safety plans, or Suicide Behavior and Overdose Reports attend a Mental Health in-service.¹⁰⁴ The in-service focused on VHA suicide prevention screening, safety planning, and documentation requirements. However, the OIG did not find evidence in the in-service training materials that staff were reeducated about the role of the suicide prevention team as an adjunct to other clinic providers, despite facility leaders’ awareness that prescribers were concerned about the role of the suicide prevention team in the same-day access clinic. Additionally, the OIG learned that after the in-service, a prescriber told the chief of Mental Health about being “very disappointed with this presentation today,” adding that instead of open discussion about reducing veteran suicides, the prescriber felt the in-service focused on documentation requirements.

The OIG concluded that although the Mental Health in-service clearly communicated providers’ responsibilities related to VHA suicide prevention, the failure to address the role of the suicide prevention team in the in-service was a missed opportunity to respond to prescribers’ concerns and was not consistent with HRO values.

¹⁰⁴ The chief of Mental Health required clinical and administrative Mental Health staff to attend the in-service.

Conclusion

The OIG substantiated that access to mental health care was delayed related to BHIP and psychotherapy consult completion not meeting VHA's required time frame. Approximately 40.5 percent of BHIP consults did not meet the required completion time of 30 days from the PID. For psychotherapy consults, 39.3 percent of general psychotherapy, 39.5 percent of PTSD, 27 percent of military sexual trauma, and 67.8 percent of couple's therapy consults were not completed within 30 days of the PID. The OIG identified no adverse clinical outcomes but would expect facility leaders to proactively mitigate delays in consult completion.

The OIG did not substantiate that psychotherapy is not available until BHIP consultations are completed. Clinic providers did not fully understand the psychotherapy consult process; specifically, providers could enter psychotherapy consults without a BHIP assessment if clinically indicated and if specialty mental health services could address the patient's care needs.

Prescribers, including the former section chief of the clinic, were unaware that psychotherapy consults could be submitted independent of the BHIP consult process. The OIG learned of impaired communication in the clinic surrounding this issue. Mental Health leaders were aware of BHIP consult delays, and initiated process improvements. However, Mental Health leaders' response to clarify the psychotherapy consult process was deficient and led to misunderstandings among providers seeking care for their patients. These failures in communication delayed referral for timely mental health evaluations.

The OIG substantiated prescribers left the clinic due to their concerns regarding patient safety issues, workload burden, and burnout. Although the Mental Health Service leaders engaged in process improvements to address prescribers' perceived workload burden and to backfill clinic position vacancies as required by VHA, the Service lacks an organized process to evaluate why prescribers leave, which would likely aide leaders in staff retention.

Facility leaders opined that recruiting Mental Health staff is difficult due to a scarcity of mental health providers in the area, a high cost of living, and a lack of robust and well-established educational affiliates near the facility to recruit mental health providers. Although the facility has met the minimum staffing requirement for outpatient Mental Health, there are gaps in staffing, which facility leaders continue to address through recruitment efforts, as well as implementing hiring incentives.

The OIG did not substantiate prescribers are providing care outside of their scope of practice. Prescribers practiced within their privileges or scopes of practice, as applicable, but expressed that a lack of support from psychologists, social workers, and therapists posed a potential patient safety risk as clinical pharmacy specialists felt pressure to provide care outside of their scope of practice. Mental Health leaders made operational and workflow changes to the same-day access clinic and clarified the role of a clinical pharmacy specialist. However, facility leaders struggled to uphold The Joint Commission standards of communication among Service-line leaders.

The OIG substantiated facility Mental Health leaders discouraged clinic providers from entering community care consults by expressing the need to minimize expenses and maintain patient care at the facility. Clinic providers reported conflicting perceptions of Mental Health leaders' guidance, with some providers understanding community care consults as permissible and others believing consults were discouraged. However, nearly all the prescribers, as well as non-prescribing clinic providers, submitted community care consults during the inspection period.

The OIG did not substantiate that the suicide prevention team failed to support prescribers with clinical duties such as suicide risk evaluation, safety planning, crisis management, or post-hospitalization follow-up for clinic patients, including patients with a PRF. The OIG identified a general misunderstanding by some prescribers about the role of the suicide prevention team.

The suicide prevention team failed to monitor and manage VHA-required follow-up care for two patients with PRFs. The suicide prevention team did not ensure required follow-up for two patients with PRFs. The OIG did not identify adverse clinical outcomes; however, opportunities to address the patients' heightened suicidal risk were missed.

Mental Health Service reeducated Mental Health staff about care responsibilities to suicidal patients, including those with a PRF, but did not uphold the HRO value of clear communications and responding to staff concerns regarding the role of the suicide prevention team. A Mental Health in-service focused on VHA suicide prevention screening, safety planning, and documentation requirements but did not address the role of the suicide prevention team as an adjunct to other clinic providers, despite facility leaders' awareness that prescribers were concerned about the role of the suicide prevention team in the same-day access clinic.

Recommendations 1–7

1. The Charles George VA Medical Center Director evaluates processes for mental health consult scheduling, including community care referrals, and ensures patients are offered timely appointments, per Veterans Health Administration policies.
2. The Charles George VA Medical Center Director confirms outpatient Mental Health staff receive education about Veterans Health Administration and facility policies related to mental health consult processes, including timeliness and community care consults.
3. The Charles George VA Medical Center Director evaluates the design, staffing, and implementation of the Behavioral Health Interdisciplinary Program to ensure the program supports timely access to mental health care and takes action as appropriate.
4. The Charles George VA Medical Center Director confers with Mental Health leaders to identify, track, and mitigate barriers to staff retention and takes appropriate action.
5. The Charles George VA Medical Center Director ensures Mental Health leaders review current communication practices within Mental Health operations, in accordance with Veterans Health Administration High Reliability Organization values and principles and considers the use of Veterans Health Administration resources, such as the National Center for Organization Development.
6. The Charles George VA Medical Center Director ensures Mental Health leaders educate Mental Health clinic staff on the role of the suicide prevention team in patient care.
7. The Charles George VA Medical Center Director reviews and evaluates processes for monitoring and managing Veterans Health Administration-required follow-up care for patients with high risk for suicide patient record flags, including scheduling and tracking of required follow-up appointments, and monitoring compliance.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 8, 2023

From: Director, VA Mid-Atlantic Health Care Network (10N06)

Subj: Healthcare Inspection—Concerns With Access to Care in the Outpatient Mental Health Clinic at the Charles George VA Medical Center in Asheville, North Carolina

To: Office of the Under Secretary for Health (10)
Director, Office of Healthcare Inspections (54HL07)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. I appreciate the opportunity to review the draft report: Concerns with Access to Care in the Outpatient Mental Health Clinic at the Charles George VA Medical Center in Asheville, North Carolina.
2. I would like to thank the OIG Inspection team for a thorough review which identified opportunities for improvement.
3. I have reviewed the OIG recommendations, facility response and action plan and am committed to supporting process improvement and sustainment at the Charles George VA Medical Center and throughout VISN 6.

(Original signed by:

Paul S. Crews, MPH, FACHE
Network Director

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 7, 2023

From: Director, Charles George VA Medical Center (637)

Subj: Healthcare Inspection—Concerns With Access to Care in the Outpatient Mental Health Clinic at the Charles George VA Medical Center in Asheville, North Carolina

To: Director, VA Mid-Atlantic Health Care Network (10N06)

1. I have reviewed and concur with the recommendations and the responses to the VA OIG's findings from the Concerns with Access to Care in the Outpatient Mental Health Clinic at the Charles George VA Medical Center in Asheville, NC.
2. We appreciate the opportunity for this review as a continuing process to improve the care to our Veterans, who we are proud to serve.

(Original signed by:)

Stephanie Young
Executive Director

Facility Director Response

Recommendation 1

The Charles George VA Medical Center Director evaluates processes for mental health consult scheduling, including community care referrals, and ensures patients are offered timely appointments, per Veterans Health Administration policies.

Concur.

Target date for completion: March 31, 2024

Director Comments

The Charles George VA Medical Center Director (Executive Director) evaluated processes for mental health consult scheduling, including community care referrals and ensuring patients are offered timely appointments per policies. A monthly work group was established to continue evaluating policies and processes for Mental Health consult scheduling, community care referrals and ensuring Veterans are offered timely appointments. The work group includes the Mental Health Chief, the Community Care Chief, the Mental Health Administrative Medical Support Assistant and the Group Practice Manager. The work group reviews the timeliness of appointments being offered to patients for psychotherapy, PTSD, military sexual trauma, and couples therapy consult wait times. Data and recommendations are presented monthly to the Quality, Safety and Value Council, which is attended by senior leadership including the Executive Director, and a monthly summary report is presented to the Executive Leadership Board.

Recommendation 2

The Charles George VA Medical Center Director confirms outpatient Mental Health staff receive education about Veterans Health Administration and facility policies related to mental health consult processes, including timeliness and community care consults.

Concur.

Target date for completion: December 31, 2023

Director Comments

The Charles George VA Medical Center is implementing a mandatory training on the Veterans Health Administration (VHA) training site Talent Management System (TMS) with an associated test on Veterans Health Administration (VHA) facility policies related to mental health consult processes, including timeliness and community care consults. All Mental Health staff will be required to complete this training. Completion of the training and the associated test

is monitored through the Quality, Safety and Value Council, which is attended by senior leadership including the Executive Director, and a monthly summary report is presented to the Executive Leadership Board.

Recommendation 3

The Charles George VA Medical Center Director evaluates the design, staffing, and implementation of the Behavioral Health Interdisciplinary Program to ensure the program supports timely access to mental health care and takes action as appropriate.

Concur.

Target date for completion: March 31, 2024

Director Comments

The Executive Director evaluated the design, staffing, and implementation of the Behavioral Health Interdisciplinary Program (BHIP) to ensure it supports timely access to mental health care and the facility is taking action as appropriate. The Mental Health Service is using the VA Office of Mental Health and Suicide Prevention approved template Enhanced BHIP Team Implementation Checklist to develop a robust program with timely access to mental healthcare. The facility is also using the BHIP staffing model based on the BHIP Collaborative Chronic Care Model Enhancement Guide.

Reports on the status of the Enhanced BHIP Team Implementation Checklist, BHIP staffing, and BHIP access for offering timely appointments are monitored through the Quality, Safety and Value Council, which is attended by senior leadership including the Executive Director, and a summary report is presented to the Executive Leadership Board. The reports will be monitored through these meetings until the facility reaches a minimum of 90 % compliance for at least 6 consecutive months for timely access with BHIP consults.

Recommendation 4

The Charles George VA Medical Center Director confers with Mental Health leaders to identify, track, and mitigate barriers to staff retention and takes appropriate action.

Concur.

Target date for completion: June 30, 2024

Director Comments

The Mental Health Chief, Chief of Staff and a Human Resources representative met with the Executive Director to discuss, track and mitigate barriers to staff retention and take appropriate actions. Actions taken include implementing the special salary rates, recruitment bonuses, staff

retreats, hybrid telework schedules and pay flexibilities. Mental Health Service staffing levels are monitored through the Quality, Safety and Value Council, which is attended by senior leadership including the Executive Director, and a summary report is presented to the Executive Leadership Board. Staffing will be monitored through these meetings with a target goal of 7.72 staff per 1,000 Veterans as reported by the [VHA Support Service Center] VSSC Performance Measure Report metric mhsa2 (Outpatient Mental Health Staff to Treated Patient Ratio) with the facility reaching and maintaining 100 % compliance for at least 6 consecutive months.

Recommendation 5

The Charles George VA Medical Center Director ensures Mental Health leaders review current communication practices within Mental Health operations, in accordance with Veterans Health Administration High Reliability Organization values and principles and considers the use of VHA resources, such as the National Center for Organization Development.

Concur.

Target date for completion: December 31, 2023

Director Comments

The Charles George VA Medical Center is requiring a mandatory training session on High Reliability Organization (HRO) principles for Mental Health Service leaders. The VISN 6 HRO Officer and the facility HRO Coordinator are conducting face-to-face training of Mental Health leaders on communication practices based on HRO values and principles.

Recommendation 6

The Charles George VA Medical Center Director ensures Mental Health leaders educate Mental Health clinic staff on the role of the suicide prevention team in patient care.

Concur.

Target date for completion: December 31, 2023

Director Comments

The Charles George VA Medical Center is implementing a mandatory training on the VHA training site Talent Management System (TMS) with an associated test on the role of the suicide prevention team in patient care. All Mental Health staff will be required to complete this training annually. The suicide prevention team is conducting face-to-face training on their role in patient care for Mental Health clinic staff. Completion of the trainings is monitored through the Quality, Safety and Value Council, which is attended by senior leadership including the Executive Director, and a monthly summary report is presented to the Executive Leadership Board.

Recommendation 7

The Charles George VA Medical Center Director reviews and evaluates processes for monitoring and managing Veterans Health Administration-required follow-up care for patients with high risk for suicide patient record flags, including scheduling and tracking of required follow-up appointments, and monitoring compliance.

Concur.

Target date for completion: March 31, 2024

Director Comments

The Mental Health Chief developed a High-Risk Flag (HRF) Compliance Tool to track Scheduled Appointments, Completed Appointments, and No-Show Follow-Up attempts for each measure:

- HRF2 (High Risk Flag2 - Definition per VSSC Data Dashboard - *% of patients with a new assignment or reactivated HRF who received at least 4 mental health visits within 30 days of flag initiation*)
- HRF3 High Risk Flag3 - Definition per VSSC Data Dashboard - *% of patients with a new assignment or reactivated HRF who received at least 1 mental health visits 31-60 days after flag initiation*), and
- HRF4 (High Risk Flag4 - Definition per VSSC Data Dashboard - *% of patients with a new assignment or reactivated HRF who received at least 1 mental health visit 61-90 days after flag initiation*).

The Mental Health Chief will monitor the HRF Compliance Tool and HRF Dashboard monthly and report data through the Quality, Safety and Value Council, which is attended by senior leadership, including the Executive Director, and a summary report is presented to the Executive Leadership Board. The HRF Compliance tool will be monitored monthly with a goal of 90% compliance for at least six consecutive months.

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